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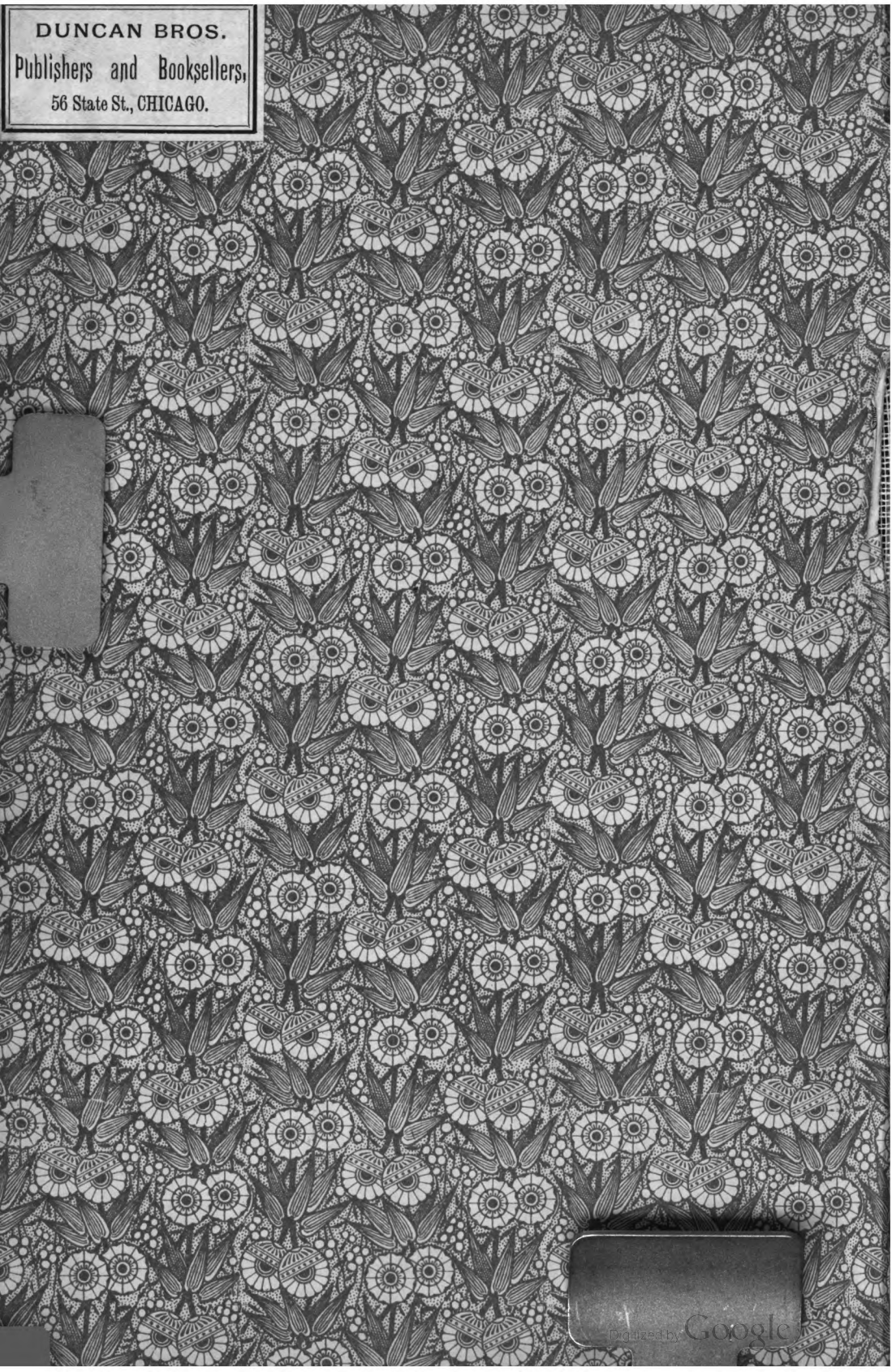
DISEASES OF THE RECTUM.

M. AYRES, M. D.

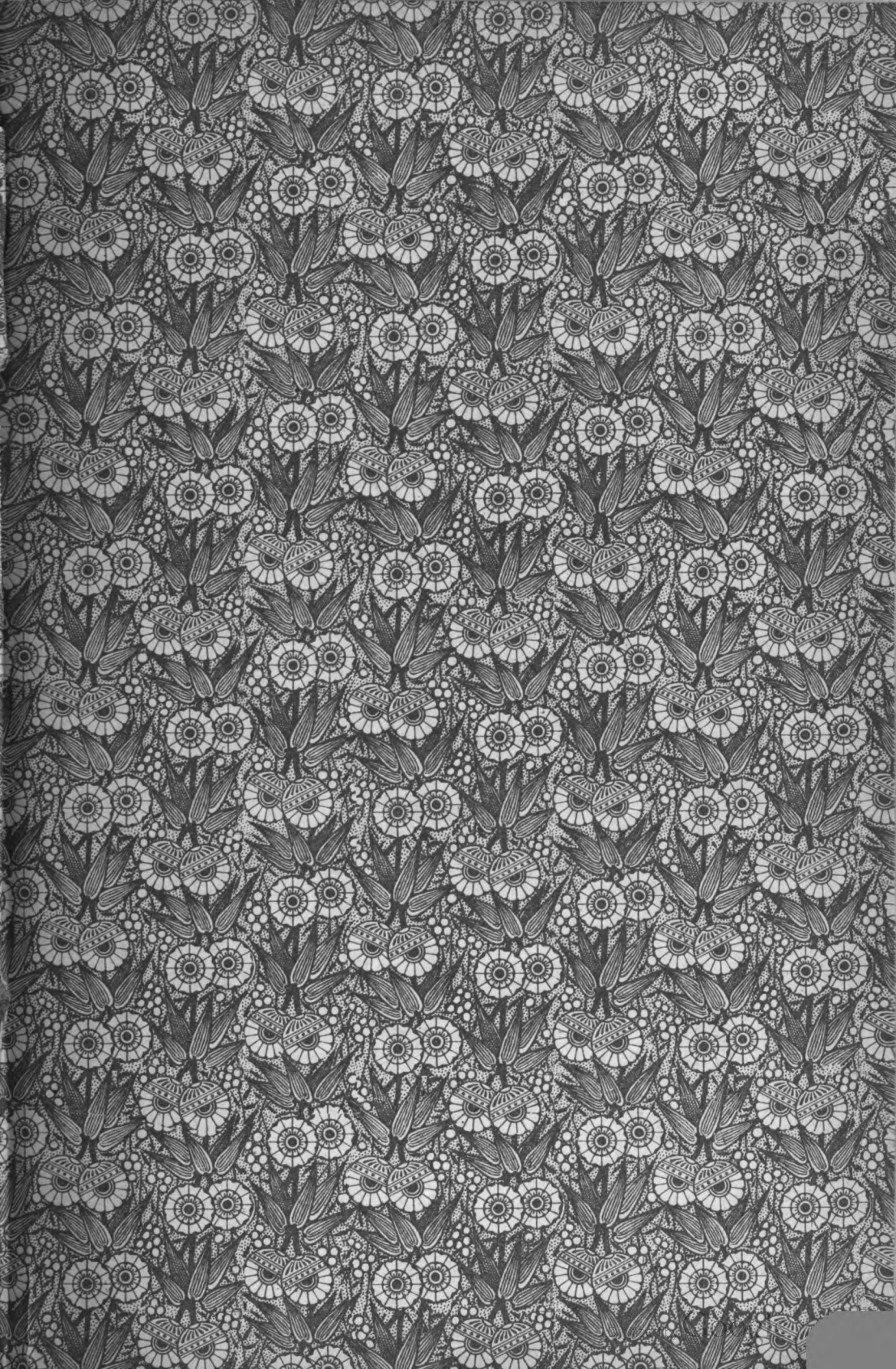
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ARTES SCIENTIA VERITAS

SOME OF
THE
DISEASES OF THE RECTUM,
AND THEIR
HOMŒOPATHIC AND SURGICAL TREATMENT,
BY
MORTIMER AYRES, M. D.,

CHICAGO:
DUNCAN BROTHERS.
1884.

Medical Library

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PREFACE.

Having had occasion to treat many cases of diseases of the rectum, the author became possessed of some facts that enabled him to manage them with satisfaction. In fine, he came to have quite a repute in his neighborhood for "curing piles." Some of his colleagues, learning of his success, urged him to write a treatise on the Diseases of the Rectum. To that he objected, but finally consented to write out a few ideas on "Some of the More Common Diseases of the Rectum, and their Medical and Surgical Treatment."

In preparing the following pages for publication, the author has endeavored to condense into a convenient form as great amount as possible of practical information concerning the most common diseases of the rectum and anus. Those who look for this work to be a complete treatise on this subject will be disappointed. It expresses chiefly the results of his own experience. The author has endeavored, whenever it was possible, to illustrate the subject under consideration by reports of cases generally gleaned from his own practice, knowing that a point is emphasized in that way better than in any other. It is his earnest desire that these pages may prove helpful to the profession.

The author cannot, however, allow this small work to go forth without an earnest appeal to the charity of the reader.

Should another edition be called for, any practical suggestions or experience on any point will be gladly received, incorporated and duly credited by

THE AUTHOR.

RUSHVILLE, Ill.

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DISEASES OF THE RECTUM.

CHAPTER I.

HYGIENE OF THE RECTUM.

It is usual to commence a work of this nature with a description of the anatomy and physiology of the parts, but as these are more or less carefully considered in discussing the diseases that are treated in the following pages, they are here omitted, except so far as they bear on the hygiene of the rectum.

This is a subject in regard to which great indifference and even ignorance prevails. There is hardly a physician of the most limited experience, but who has noticed how many of the complaints connected with the rectum seem to have their origin in carelessness and neglect, through ignorance. Lack of cleanliness is a fruitful source of disease at this outlet of the body.

The individual who sits straining to get rid of the contents of the rectum is, perhaps, not aware of the damage he is doing to the parts which he is subjecting to violence, and how surely he is courting prolapsus or piles, if not abscess or fistula. In habitually neglecting the call of nature, he fails to recognize the danger incurred in loss of expulsive power from over distention, consequent costiveness from atony, inflammation, stricture and abscess.

Let us glance for a moment at what anatomy and physiology teaches us concerning the rectum. The muscular coat of the rectum consists of an external and internal layer. The external consists of a lot of fibres which run in a longitudinal direction. The internal consists of

a layer of circular fibres which circle around the rectum and grow larger and more powerful as they approach the outlet, where they are collected into two main bundles called the external and internal sphincters.

A large proportion of the external longitudinal fibres when they reach the first ring of circular fibres (internal sphincter) double around its lower border, pass upward to be inserted into the fibrous substratum of the mucous membrane of the gut.

From this arrangement it results that, when in the act of defecation these longitudinal fibres contract, they tend first to draw down and then evert the mucous membrane of the lower end of the rectum. When the evacuation takes place naturally, this protrusion is promptly retracted by the action of the *levators* and the natural contractility of the parts, but when the evacuation is difficult or impossible and the effort is prolonged or frequently repeated, the protruded mass becomes congested and swollen and is retracted with more difficulty; perhaps a portion remains outside, then the tumid and tender protrusion leads to the announcement on the part of the patient that he has had "an attack of the piles."

It is our duty then to teach those who intrust their health to us how to care for themselves intelligently in this matter, for preventive medicine takes rank before curative measures, inasmuch as it requires a wider scope of knowledge and involves a greater exercise of power.

The regular performance of this function is then one of the primary conditions of physical well being and its derangement is recognized as one of the first evidences of a departure from perfect health.

Its periodical fulfillment should be insisted on, for periodicity is one of nature's favorite habits. This should be solicited with gentleness. The danger of straining with violence should be inculcated from earliest childhood. If the evacuation can not be accomplished by moderate effort, then the cause should be sought for and removed. No person is "naturally costive," as the popular belief and the mode of expression would seem to imply.

Sometimes in the act of defecation little particles of hardened fecal matter are caught within the folds around the anus and act as sources of irritation and should be carefully removed. The anus should be wiped clean after every evacuation. The best article is soft tissue paper; all hard articles, like brown paper, corn cobs, grass, leaves, sticks, etc., should be scrupulously avoided. It is believed by many

that the use of newspaper is a fruitful cause of piles and pruritus. There is a variety of medicated paper, but the carefully selected water-closet paper is the best.*

One should never wipe the anus violently, nor when the sphincter is dilated and the mucous membrane exposed. The rectum should be emptied, the sphincter closed and then the cleansing should take place. Sufficient time should be allowed for the rectum to completely empty itself. I cannot however, speak in too strong terms against the unnatural habit that some people have of remaining long at the water closet.

It is a great help in slight as well as in severe rectal troubles if one can assume the horizontal position a few moments after stool. The hæmorrhoidal vessels have then a chance to empty themselves from the engorgement produced by straining, before the weight of the viscera is thrown upon the rectum.

When we consider how little instruction is given on the care of the rectum, we wonder that diseases of these parts are not more common, even now we will venture to say that but few persons pass through life without some disorder of this outlet of the body.

*Duncan Bros. of Chicago, carry a supply of paper medicated with Hamamelis which is excellent.

CHAPTER II.

ULCERS OF THE RECTUM.

All ulcerations within the rectum will be classed under the two heads, malignant and non-malignant. But when we speak of rectal ulcers we mean the non-malignant variety, but they are so often confounded by our authors that I think a few words on the distinctive difference between the two will not be unnecessary, for on the one hand, you can safely say to your patient, it is curable, on the other you would be very slow in making such a positive statement.

In all new growths within the rectum, when non-malignant, the tendency is to increase very slowly, and to grow away from the wall of the intestine and form pedicles for themselves, to remain movable, to project into the cavity of the intestinal canal, and not to involve surrounding parts; while with the malignant or cancerous variety the tendency is directly the opposite. With these points carefully attended to, the diagnosis between a benign polyp and a cancerous nodule in the wall of the rectum is generally very easy.

Recent careful study has shown that there is a class of tumors occupying the border line between the benign and malignant, which, either clinically or with the microscope, it is almost impossible to diagnose the difference, and Dr. Cripps,* who has made some most careful and earnest work in this department, groups all growths in the rectum as malignant, semi-malignant and simple adenoid. Generally, but not always, it is possible to distinguish between them. He says: "In the more malignant varieties, the new growth frequently spreads as a thin layer between the muscular and mucous coats. In this form it often occupies several square inches of the bowel, while its thickness does not exceed a quarter of an inch. At first the

*Cancer of the Rectum, London, 1880.

mucous membrane lies intact over such a layer, but eventually it gives way by ulceration. This ulceration sometimes begins at more than one point, so that the mucous membrane becomes honey-combed, and portions of the subjacent growth may even sprout through it. The destructive process not only destroys the mucous membrane over the growth, but after a while the new growth is itself destroyed by ulceration. While destruction is proceeding toward the center, the growth is advancing toward the circumference. In this way a crater-like mass of disease is produced, the centre of which consists of dense fibrous tissue belonging to the muscular coat of the bowel, which appears for a long time to resist the ulcerative process. The margin of the crater consists of the mucous membrane of the bowel, heaped up by the extending growth beneath it, tucking it over in such a manner as to overlap the healthy membrane. The border is at times so irregular as to represent a series of nodules rather than a continuous line."

Of all the varieties of malignant growths of the rectum epithelioma is the one most frequently met with, and this presents, here, as elsewhere in the body, under two forms. The first or cancrroid or lobulated epithelioma is the same form so commonly seen in the lip, but seldom attacks the anus. The other variety (the cylindrical epithelioma) chooses the rectum proper for its development, and is formed above the sphincter. It is very soft and very vascular, and therefore, prone to bleed from slight causes, and rapidly undergoes degeneration and ulceration, and infiltration of the surrounding tissues.

Next we may have scirrhus, encephaloid, colloid, etc., but they are more uncommon and present their distinguishing features here as elsewhere in the body, and are here spoken of because they may be mistaken for simple rectal ulcer.

CLASSIFICATION OF THE NON-MALIGNANT VARIETIES.

I have adopted the following classification for non-malignant ulcers of the rectum : 1. Simple ; 2. Tubercular, including scrofulous ; 3. Dysenteric ; 4. Venereal ; 5. Those due to stricture.

Simple Ulcers.—If we examine carefully into each case of simple ulcer, it is my belief we will always find it to be of traumatic origin. The pressure and passage of hardened feces is the most frequent cause of the traumatism. For by this means a fissure is often pro-

duced within the grasp of the sphincter, and a projecting hæmorrhoidal tumor may become ulcerated for a considerable extent.

Among other frequent causes may be mentioned, pressure of foreign bodies, as fish-bones, fruit stones, etc., which have been swallowed.

Any direct violence to the rectum may produce ulcers, and in women the injury to which they are subject in child-birth, viz., the bruising of the rectal wall between the head of the foetus and sacrum, is believed by many to be the cause of the greater frequency of ulceration and stricture than in men.

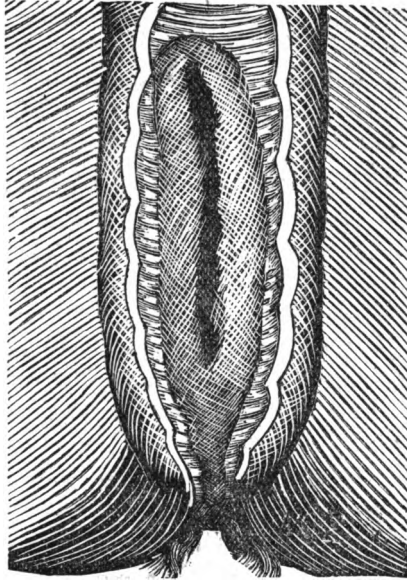
Tubercular Ulcers.—Some authors speak of two varieties of ulceration met with in persons of tubercular diathesis, one due to actual deposit and softening of tubercle, the other a simple ulceration, containing no tubercular deposit, but modified in its course by the patient's condition of mal-nutrition. The former may properly be called tubercular ulceration, and the latter the ulceration of the tuberculous.

The former certainly must be very rare. To my knowledge I have never met one. Of the latter it is truly, a simple ulcer in the phthisical patient, modified in its course and characteristics, by the general condition. It may result from any of the causes previously mentioned. It may occur either within the rectum or at the anus, and be of any size from a small spot to a sore covering the whole lower part of the rectum. It may commence quite small and extend on the surface, or it may extend in depth and perforate the wall of the rectum and produce an abscess ending in a fistula.

Any one who has treated many cases of tubercular consumption will know how frequently they meet abscess and fistula in this neighborhood, and it is my experience that the majority of these arise from simple ulcer.

CASE I. C. C., aged twenty-three, came to me on September 2, 1875, for relief from a chronic diarrhœa. He was a victim of that fell destroyer consumption, and was very weak and very much emaciated, his bowels were moving about four to six times a day, very small in quantity, and consisted mostly of pus often streaked with blood, no pain, but exhausting; examination revealed an ulcer, pear-shaped, with the small end nearest the anus; local applications of many kinds were tried with but little relief. On November 2d he came complaining of pain and swelling and, on examination, found the ulcer had perforated near its lowest end, and there was considerable swelling and tenderness in the ischio-rectal space. Treatment seemed of no avail in aborting the abscess, which gradually gathered and pointed near

the anus, where, upon opening it, I saw some dark little bodies passing, which, upon close examination, proved to be blackberry seeds. These seeds no doubt lodged in the end of the ulcer, perforated their way through the wall and set up an abscess which became a fistula.



TUBERCULAR ULCER OF THE RECTAL WALL.

Dysenteric Ulcers.—In dysenteric ulceration the fibrous exudation which is infiltrated into the tissues produces compression, and as a result we have a slough which, when it is cast off, leaves an ulcer, and if superficial, may soon regain its usual state, but if deep, still may heal by the usual callous cicatrix, and a stricture be the result. The ulcers found in these cases vary much in size, location and appearance, but they are generally large and their favorite site is the rectum or sigmoid flexure.

Venereal Ulcers.—These may be gonorrhœal or syphilitic in origin, and, if the former, the inflammation may be very severe. During its height the rectum will be swollen, hot, red and granular, with an abundant discharge issuing from the anus.

Chancroids.—These ulcers are said never to pass above the sphincter, and are generally seen on the skin just around the anus or just within the canal. They present the same characteristics as in other parts of the body, and are more common in women than in men. The class of women in whom they exist is a valuable aid to their diagnosis.

Stricture.—Not only is ulceration a common cause of stricture, but any form of stricture is liable, by its obstructive action, to set up ulceration in the walls above. There is dilatation of the rectal pouch, with its accompaniment—hypertrophy of the walls—produced by the effort to overcome the obstruction. Next an ulcerative action is set up in the mucous membrane, probably due to the irritation and traumatism of feces.

DIAGNOSIS OF RECTAL ULCERS.

From what has been said of the etiology of these benign ulcers, it is plain that they must present many variations in appearances, yet the diagnosis of each from the other, will not generally be difficult if we give careful attention to the history, the appearance of the lesion, and its course.

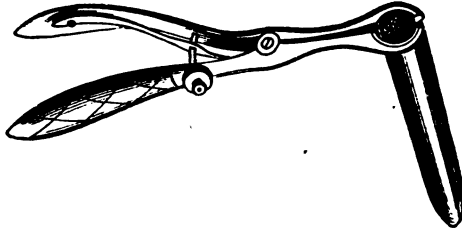
A small ulcer within the grasp of the sphincter, might easily escape observation in a superficial examination, but all ulceration within four inches of the anus are within the reach of actual touch or vision, and should not escape detection when the examination is properly conducted.

In some cases a gentle pulling apart of the lips of the anus, with some straining on the part of the patient, will bring into view a small ulcer.

In others a digital examination will reveal an eroded and painful spot, and on withdrawing the finger it will be found to be stained with blood.

But I would say in all cases the diagnosis is easy, and there is but one way to make it, and that is with Ether and the speculum, and from my experience with physicians this is the least used. If we have a lady for a patient it is much easier to prescribe some remedy in conjunction with a local application, and trust to a kind providence, than it is to gain her consent to a thorough examination. The existence of a chronic diarrhoea or a discharge of any kind from the rectum is a good and sufficient reason for a thorough examination; with

an anæsthetic, a good speculum and a dilated sphincter, no one need



RECTAL SPECULUM.

be in doubt as to the existence of ulceration of the rectum. The existence of an ulcer being decided, its nature alone remains to be determined, and we have, as we proceeded, given some of the principal points in diagnosis, and to them we refer the reader. In the majority of cases, the ulcer will be found to be of the simple variety first described, only modified more or less by the general condition of the patient, therefore in the treatment of ulceration we need only consider the simplest form, leaving out irritable ulcer of the anus (as that is worthy of an article by itself) and the question of stricture, as our space is too limited.

TREATMENT, MEDICAL AND SURGICAL.

There are few maladies more baffling to the surgeon than ulcerations and strictures of the rectum. I believe that my failures have been almost as frequent as my successes.

And in a severe case of ulceration, let the general condition of the patient be as it may, I have never been able to benefit the patient unless absolute rest was persevered in for some weeks. Even with rest, diet, and appropriate treatment, your task will be no easy one. In the way of local applications, suppositories answer the best



purpose. The menstrum should be of some substance which may be easily dissolved at the temperature of the body. I have found gelatine* the best, and in the way of drugs I have found more satisfaction with Iodoform and Hydrastis. I was brought to the use of these suppositories by finding out that a speculum examination two or three times a week caused too much irritation.

*These are sold by Duncan Bros., Chicago.

To render the patient's rest in bed more endurable, and to secure local rest to the part, I have found it best to combine about one-tenth of a grain of Morphine with the suppository.

In some cases where the ulceration is quite high up in the rectum, good results may be obtained by the daily use of injections, which is best accomplished by a long rubber tube, obtained of any instrument maker, attached to an ordinary Davidson's syringe. With the syringe the best results have been obtained by me with Nitrate of Silver, fifteen grains to three pints of water.

It is very difficult to point out a general constitutional treatment, for each case will have to be treated according to the peculiar symptoms present. I generally begin my treatment of rectal ulcers with Sulphur, especially if the case is complicated with piles. The general indications for the use of Sulphur are : diarrhœa early in the morning, stitches and soreness in the anus, stools almost involuntary, cramps in the calves and soles at night, extreme emaciation, whole abdomen sore to touch. My note-book gives the following cases, which I am sorry are not more complete.

CASE II. Mr. W., aged forty-six, had chronic diarrhœa since leaving the army, much worse lately, diarrhœa of pus and mucus, hurrying him out of bed in the morning, generally about once in three days would have a hard costive stool. Any labor brought on an increased number of stools. Examination revealed an ulcer with ragged edges on posterior surface of rectum, extending upwards. Prescribed Sulphur 6x with complete rest, to be maintained four weeks, and longer if required; he reported in two weeks much better, and put up a pitiful face about his poverty and that he must work; after warning him of his danger, allowed him to do as he pleased. He reported in about six months afterward, that he was as bad as before, but that he must work. I tried local applications, but he soon passed from under my observation, and two years afterward I heard of his death, but no particulars.

After Sulphur I place Arsenicum as next on the list. It is suitable in the run-down constitution, induced by extreme weakness. prostration, diarrhœa, with painless, offensive stools.

CASE III. Sam E., aged forty-three, suffered with offensive stools and flatus for years, worse at times. Carpenter by trade; could only work about one-half his time on account of extreme weakness; examination revealed a large irregular shaped ulcer just above the sphincter, discharging an offensive fluid, and several small patches at different parts of the canal, reminding one of aphthæ of the mouth. Complained of burning and itching, was extremely restless, worse at

night. Arsenicum 3x brought relief in two days and in one week was at work contrary to all orders. It is now three years since I first prescribed, but he continues his work most of the time and when he gets very bad takes Arsenicum. He refuses all further treatment than that. Being a government pensioner will probably explain his reason.

Nux vomica and Phosphorus will often be valuable helps in the cure of cases, and in relieving particular symptoms, these with Lycopodium, Ignatia and Graphites, the well known symptoms of which it is not necessary for me to mention here, complete the list, except *Æsculus hippocastanum* which of late has given me much satisfaction. When there is much aching in the back, worse from exercise of any kind, constipation, and if the case is further complicated with hæmorrhoids it is much more successful.

Yet with the best chosen remedy you will often fail unless complete rest is enjoined, and some local application is used, and even with th m you will sometimes fail. But if the above treatment is followed, you will be reasonably satisfied with the result.

CHAPTER III.

FISSURE OR IRRITABLE ULCER.

This is a longitudinal crack or wound in the mucous membrane that is grasped by the sphincter. It is an exceedingly painful, and by no means an uncommon affection.

Frequency.—It is incident to all ages, but is more commonly met with in those of middle life.

Age.—Dr. Mabboux gives an account of a child two months old with a fissure, but none so young have fallen under my observation. It is a much more frequent disease of childhood than is commonly supposed.

Nature.—There may be two or more fissures, but generally only one exists and that at the posterior or dorsal border of the anus, but it may be perineal or lateral.

If we are called upon at an early stage in the disease, we find it looks just as if the mucous membrane had been torn by a hard costive stool. It has about the same appearance as a crack we often see in the middle of the lower lip of some individual, which is very slow to heal; bleeding readily from laughing, or any motion which puts the lips upon the stretch.

Fissure of the anus follows for a time about the same course as the crack upon the lip; at first the edges are sharp and the surface florid but later the edges become raised and indurated and the surface assumes an ash color.

Causes—Syphilis is the remote cause of many fissures, but the immediate cause is straining in passing large hard, and dry stools; fissure may sometimes result from a severe diarrhoea. It is frequently the sequela of confinement and the accompaniment and occasional result of piles and polypus.

Diagnosis.—As a rule fissure is supposed to be hæmorrhoids ; patients tell you that they have a discharge of blood and matter, a swelling outside the bowel, and pain at and after stool, and they believe they have piles. Unfortunately, not unfrequently the medical attendant is satisfied with the patients diagnosis, and treats the case as one of external hæmorrhoids. But I would say, generally when a patient complains of great pain during or after defecation, that it is not piles he is suffering from and certainly not uncomplicated piles.

I have known patients who for hours could not bear to stir from one position, the least movement causing an exacerbation of the pain. This agony induces the sufferer to postpone relieving the bowels as long as possible, even for days at a time, until the costive condition of the bowels becomes almost a second nature, and they only move when cathartics are used ; then the pain is almost unbearable. In some cases after the bowels move the pain ceases and perhaps does not return at all until another evacuation takes place, but often it continues very severe, of a burning character, or it is a dull heavy pain, with throbbing that lasts for hours. In some instances the pain does not set in until a quarter or half an hour after the bowels have acted.

As the disease progresses, there is a constant desire to urinate, or retention of urine, dilatation of the bladder, pains, cramps, and numbness, even loss of muscular power in the lower extremities, generally of the left side. When the disease is fully established, the pain will be induced by sneezing, coughing, or micturition, and in time so violent does the agony become, that individuals thus affected even avoid taking sufficient nourishment in order to lessen the quantity of feces. Sitting is painful and riding almost impossible, even at time the patient is obliged to remain in a recumbent position.

CASE IV. James A. presented himself to me in December, 1876, for treatment for what his medical adviser had called *liver complaint and heart disease*.

He reported that he was very costive, passed large, hard and difficult stools, with so much pain at defecation that his physician had advised him to restrain the movement of the bowels for two or three days and then use injections.

He was very anæmic and complained of great distress about his heart, loss of breath upon exertion of any kind. Constant desire to urinate, the pain after defecation was of a burning stinging nature and would last from two to six hours, although it would not generally commence until about fifteen to thirty minutes after each evacuation.

He had never received any treatment for the fissure (actually did not know any existed, his physician having told him it was piles) due to his liver trouble.

Upon examination I detected a fissure, the largest and deepest I had ever seen. The sphincter muscles were contracted and apparently enlarged, and the examination was productive of great pain. The next day, being assisted by Dr. F. A. Noyes, of Ray, I made an incision the full length of the fissure, and deep into the sphincter ani. The relief was immediate.

I put him upon the use of *Nux vom.* 3x, four pills every three hours, which gradually relieved his costiveness, and up to this time (1883) has had no return of his fissure trouble.

Curling relates the case of a patient of his who adopted the dangerous habit of inhaling Chloroform, while at stool, and could not be persuaded to go to stool without this anæsthetic.

Sex.—It is stated that women are more subject to fissure than men. I have observed it frequently in both sexes, and am unable to say that the one is more susceptible to it than the other. Want of proper exercise certainly predisposes to it. Women are sedentary, both from habit, and the usages of society; in them also, constipation, one of the exciting causes is frequent, partly ensuing from their habitually neglecting to obey nature's calls, which, for a time, they can do with less inconvenience, in consequence of the greater capacity of the pelvic cavity than in the male. Men are sedentary from the various occupations in the affairs of life; and among the working class, many are compelled, by the nature of their business, to maintain the sitting posture for a number of hours consecutively, and in these, all diseases of the rectum are extremely prevalent.

The predisposing causes are constriction of the anal orifice. The exciting causes are constipation, induration of the fecal matter, and the violent action of the expulsive muscles requisite for its evacuation.

The examination necessary for ascertaining the nature and extent of the disease is always attended with some pain, and is best made by lying on the side; the patient raising the upper buttock with his hand, then with the fore-finger the surgeon gently opens the anus, telling the patient at the same time to strain down. You will then be able to see just within the orifice an elongated, club-shaped ulcer.

In some cases the examination, though made as gently as possible, will be so painful that you will be obliged to use Chloroform or some other anæsthetic.

Frequently the side of the fissure is marked externally by a small clavate papilla; sometimes by a swollen and inflamed piece of skin, and in this case it frequently ulcerates through the portion of the integument, and forms a small but extremely painful fistula.

When upon examination you find this club-shaped papilla protruding from the anus, you may be certain that an ulcer exists; and I may here mention that when operating, this growth should be snipped off, or the case may not do well, as it falls down into the wound and retards or quite prevents healing.

My experience fully justifies me in saying that, in children and recent cases, it is not necessary to resort to an operation. For strict attention to cleanliness,—the use of some soothing application and the Homœopathic remedy to relieve the constipation—will remove the difficulty in a few days.

TREATMENT—SURGICAL.

In the treatment of cases of long standing, if the base of the ulcer is gray and hard, and if on passing the finger into the bowel you find the sphincter hypertrophied and spasmodically contracted, feeling, as it often does, like a strong india rubber band with its upper edge sharply defined, nothing but the adoption of such means as will utterly and entirely prevent all action of the muscle, for a greater or less length of time, is likely to effect a cure.

Some authors specify the time during which this disease may be curable without an operation. If it has existed three months they say that the attempt is hopeless. But really the time is not of importance, the question is: what pathological changes have been brought about?

The credit of originating the operation for the cure of this painful complaint is due to the distinguished French surgeon Boyer. His operation was a free division of the sphincter muscle, a procedure unnecessarily severe. Dupuytren practiced a slighter incision than the operation performed by Boyer, and the late Mr. Copeland, of England, was content with making a simple superficial incision of the part. I am convinced that this is not sufficient, but that at least a few of the fibres of the sphincter muscle must be divided.

Dr. Curling writes that he once had an opportunity to examine the rectum of a lady suffering from this affection whilst she was under the influence of Chloroform, and the parts being very lax, and in a

good light, he was able to bring the ulcer well into view, and could distinctly perceive the fibres of the sphincter forming the bottom of the ulcer.

Now it is clear, that in such a case, or in an ulcer which has destroyed the mucous membrane, an incision through the base of the wound must reach and divide muscular fibres.

The operation is best performed by placing the patient on his left side with the nates close to the edge of the bed, and the knees well drawn up and opposite a good light, then with a straight probe-pointed bistoury carried well up into the rectum, an incision is made through the whole length of the ulcer from within outwards, dividing a few fibres of the sphincter muscle. The operation is over with in such a short time that it is generally unnecessary to give an anæsthetic, although the pain from cutting is very severe. There is another mode of operating which is praised very highly by a great many, that is, after placing the patient in the same position, use a sharp-pointed bistoury, cutting from *without inward*, having previously introduced a speculum to protect the mucous membrane on the opposite side, from the point and edge of the knife.

I have never been troubled with hæmorrhage, but if any vessel should be seen pumping blood, it may be seized and tied.

I always insist upon moving the bowels with an injection in the morning before the operation and use the injection every day, afterwards for a period of ten days. With this precaution the after treatment becomes very simple, the parts being left very much to themselves.

The effect of the operation is remarkable. It at once relieves the severe symptoms, the pain experienced afterwards being merely the soreness of the wound, and it rarely fails to secure the healing of the ulcer in the course of ten days or two weeks. The progress of the healing must be watched from time to time, for I have known of disappointment ensuing, and the painful symptoms returning after the case had been given up, under the supposition that the patient was well.

CASE V. Nathan W., aged fifty-one, reported October 2, 1879, that he had great pain after each stool lasting about two hours. He had suffered with this pain for the past two or three years, but lately the pain had increased very much. He had formed the habit of having his operation of the bowels every evening, so he could lie down afterwards. Had tried several physicians with no benefit. His stools were

large, hard and difficult to pass, sometimes the constipation alternated with diarrhœa; at these times he was much worse. He is tall, thin and very irritable. He refused any operative measures whatever. Prescribed Nux vom. 3x, *ter a die*, to report in a week.

October 9th no better, and apparently suffering more pain. Gave Phosphorus 3x.

October 16th reported much worse, now having morning diarrhœa; stools brown with slimy mucus and often escaping when attempting to pass wind. Gave Aloes 3x.

October 26th reported, diarrhœa was controlled almost immediately with the medicine, but the pain was no better, would not be relieved for three to five hours after stool, and therefore gave his consent to an operation, so on November 1st, assisted by Dr. J. W. Mitchell, without any anæsthetics; I operated, cutting through the ulcer and about one-third of the sphincter, the pain from operating was very great lasting about fifteen minutes, then the relief was permanent.

On January 6, 1880, while suffering with a slight attack of constipation, some pain returned, but was removed very soon under Nux vom. 3x, since which time he has remained well to this date, February, 1884.

MEDICAL TREATMENT OF FISSURE.

In the treatment of fissure Homœopathic literature is almost silent, having very little to say about it, and in most instances when mentioned it has been confounded with, or in complication with hæmorrhoids.

I have been able to find only two * articles on the subject in our publications, and both are excellent and will repay perusal.

Many physicians ignore the possibility of successful medicinal treatment entirely and rely on the knife; while others look with some degree of contempt on the knife, and pretend to accomplish everything with remedies. I do not doubt for a moment that the opposite opinions are both the offspring of honest convictions, but I do not believe that large experience can corroborate them. For myself I am of the opinion that a fair proportion of the cases can be cured by remedies, yet the majority will require the knife.

Old School authors recommend mild laxatives; figs soaked in sweet oil, the latter being a favorite domestic remedy, and advise to have the bowels moved in the evening, which is a splendid suggestion, as the rest is very beneficial and the pain does not continue as long when one is lying down. They also recommend ointments of which the

* North Am. Jour. of Hom., p. 70. Trans. of Am. Inst. of Hom., 1883, p. 422.

following, from Allingham's work on Diseases of the Rectum has proved to be the favorite :

Hydrag. sub. chloride	-	-	-	-	-	-	grs. iv.
Pulv. Opii.,	-	-	-	-	-	-	" ij.
Ext. Belladonnæ,	-	-	-	-	-	-	" ij.
Ung. Sambuci,	-	-	-	-	-	-	" ʒj.

To be applied frequently.

If ointments do not agree, a resort is had to lotions, such as Goulard water with opiates and sedatives, but nowhere in Allopathic literature (to my knowledge) can a case be found that has been treated successfully with internal remedies alone, nor are they recommended; their treatment being the combined internal and external treatment, the latter including surgical measures. How different is our mode of treatment. I shall try to lay down here my own experience as well as that I am able to cull from our literature.

First it will be necessary to discriminate between cause and effect, for it will be impossible to effect a permanent cure if the cause remains unremoved, for it follows that if displacement of the uterus, hæmorrhoids or constipation, etc., are the cause, or even if they are only disturbing elements, they must first be removed.

I do not intend here to point out a line of treatment affecting the causes, but I shall give only the indications by which a remedy may be successfully employed in cases of uncomplicated fissure, or in cases in which the complication has been removed while the fissure remains. The remedies employed are not many in number.

Nitric acid stands at the head as the one most frequently used. It is the general observation of most Homœopathic physicians that Nitric acid acts most favorably upon those points where the mucous membrane merges with the skin, and it is just in this situation that fissures present themselves.

A glance at the symptoms of Nitric acid would indicate its usefulness in this disease even to the most inexperienced eye. On going to stool, pain in the rectum, as if something were torn away. Burning sensation in rectum and anus. On going to stool twitching in the rectum and spasmodic contraction of the anus, many hours afterward. Heat and burning in the anus after stool. Proctalgia. Prolapsus ani. Humid moisture on the anus. In addition to the symptoms having special reference to the rectum and anus, Nitric acid is Homœopathic

to a mind disturbed about its disease, desponding or irritable, as well as to a constipated condition of the bowels, and we have before us all the characteristics of a bad case of fissure.

Graphites.—Next, after Nitric acid, most practitioners place Ignatia amara, but my personal experience places Graphites next, with the following indications for its use; those cases of fissure which seem to be caused by large fecal masses which tear the mucous membrane. The difference between Nitric acid and Graphites is that, in the latter, there is no irritability of the parts, no urging desire for stool (contra Nux), no spasmodic contraction of anus, but there is a smarting and soreness and itching in the anus, worse after stool.

Graphites has been more successful with me in children, where the fissure is of recent origin and seemingly produced by the constipated condition of the bowels. If there be varices of the rectum and burning rhagades between them the remedy is better indicated.

CASE. VI. Willie C., aged seven, June, 1876, brought to the office by his father who reported that the boy suffered from excessive pain at stool, and he says his wife told him to be sure and tell the doctor that his stools were slimy and that the slime was so tough that it would seem to hold the lumps of fecal matter together, stools large and difficult to pass. Examination recorded: fissure at posterior border, but no constriction of sphincter, all the tissues were very lax and the fissure was brought plainly into view by a little straining.

Prescribed Graphites 6x twice each day, reported in a week, some better, not much pain and but little itching, continued same. I did not see him again till January, 1877, when he reported having no further trouble after taking last bottle of medicine.

Ignatia.—This remedy has done me good service in cases of fissure complicated with hæmorrhoids or prolapsus, but it has not proved as serviceable as one would suppose, from its valuable list of symptoms. It is especially suitable to nervous, hysterical females of mild, easily excited nature, with some of the following symptoms: Contractive sore pain in the rectum. Constriction of the anus in the evening, returning the next day at the same hour. Stitches from the anus deep into the rectum, one or two hours after stool, pain in the rectum as from blind piles, stools large and soft but passed with difficulty.

This closes the remedies that I put in the first class and I think, you will hardly ever need to go beyond these three, but if so, you can consult the indications under Natrum mur., Thuya occidentalis, Arsenicum, Sulphur, Rhatany.

You will find in the *N. A. Jour. of Hom.* a very interesting case cured by *Rhatany 3x ter a die*, with the following symptoms: Pain after stool as if splinters of glass were sticking in the rectum; heat and pain so intense he could not keep still after stool, sensation as if the rectum protruded and then went back with a jerk, with most horrible pain; frequent and ineffectual desire to urinate.

Dr. Eggert in *Transactions, of the American Institute of Homœopathy* reports a very interesting case cured by *Pæonia*, but of this remedy I have no experience. It may be worth trying.

Other remedies have been recommended, viz., *Hydrastis*, *Phytolacca*, *Lachesis*, *Hamamelis*, *Calc. carb.*, *Rhus tox.*, etc. For particular indications I refer to our text books on *materia medica*.

In conclusion, I can only give you my experience and that is this: In recent cases and in children, the well selected Homœopathic remedy rarely fails to cure the case in a very short time, but in those of long standing, I have never been successful in relieving by anything but division of the sphincter.

Forcible dilatation as recommended by *Recamier* of France, has been reported as very successful in curing these fissures, but I have never tried it. It seems to me to be better practice to cut through the ulcer, freshening the wound, than forcibly tearing the sphincter muscle as must be done in extreme dilatation.

CHAPTER IV.

ITCHING OF THE ANUS.

(*Pruritus Ani.*)

Nature.—Itching at the anus is a very common affection, and is an accompaniment of several disorders of the lower bowel, although it exists as a distinct affection, being due to a peculiar hyperæsthesia of the skin.

In some cases it is a most distressing malady, rendering the life of some patients almost unendurable.

It is a very intractable disease, but I am confident it is always curable, if the patient will strictly and patiently follow the advice of his medical attendant.

Age.—It is a disease almost peculiar to those who have passed the meridian of life, although no age is exempt.

Causes.—Of the several causes inducing this distressing malady, congestion of the mucous membrane of the rectum, is the most frequent. Among other causes, we find the presence of worms, or other entozoa infesting some part of the intestinal tube; accumulation of the feces in the rectum and colon, the improper use of purgatives, irritation about the neck of the bladder.

I had one very severe and intractable case following an attack of dysentery; several cases have been reported as consequent on affections of the womb.

Symptoms.—The itching is most teasing and annoying at night, when it keeps the patient awake for hours. Rubbing the part to arrest the irritation only aggravates the mischief afterward, yet few persons have sufficient self-control to prevent their seeking the

temporary relief induced by friction; and some, though capable of controlling themselves while awake, unconsciously rub the part while asleep.

It is generally stated that there is very little alteration in the aspect of the part affected and nothing is to be observed beyond a roughened, thickened and more wrinkled appearance of the skin just around the anus.

This, I think, is by no means usually the case, for I have never met a patient who could control that irresistible desire to scratch, and that alone would excoriate the skin, and in cases where long continued, the skin would become either harsh, dry and of a leathery appearance, presenting cracks from slight causes, or little ulcers which are but little disposed to heal, or the part would be moist from exudation. But what seems to be the characteristic condition—is the loss of the natural pigment of the part, which in some cases even extend as far back as the sacrum, and as far forward as the scrotum, the skin presenting a dull dead white appearance, and looking more like parchment than natural integument. I have seen a similar condition in women produced by general pruritus.

Treatment.—In pruritus ani, by whatever cause produced, the habits of life should be regulated. The patient should sleep on a mattress, and be as lightly covered as is consistent with comfort. Cold bathing or sponging should be resorted to daily, and sufficient exercise taken in the open air. All hot condiments and stimulating drinks, with tea and coffee, must be strictly avoided.

Every effort should be made to avoid friction, and the patient assured, that if he yields to his inclinations his complaint will be rendered worse and more difficult to cure.

The remedies most frequently found useful are: Arsenicum, Calc. carb., Cantharis, Carbolic acid, Collinsonia, Graphites, Hamamelis, Lycopodium, Nitric acid, Sepia and Sulphur.

Of these, Sulph., Graph., Arsenicum, Nit. acid, are the most often indicated, and I think their value stands in the order in which I have named them.

Sulphur.—Violent itching and crawling in the anus in the evening, constipation, frequent ineffectual desire for stool, after stool, tenesmus, constriction of the anus, with frequent micturition with small emissions; and the following case from my record book will show the value of Sulphur.

CASE VII. March 12, 1874, G. C., aged forty-one. Presented himself to me complaining of itching and burning in the anus which had then existed for two years, itching was worse from any exertion, ploughing was almost a torture yet his circumstances (being a farmer) were such that he must work; his bowels were constipated with hard, knotty stools, yet this alternated with a diarrhoea every two or three weeks; appetite good, sleep very much disturbed until late every night, he was in the habit of applying a cloth wrung out of cold water to get relief, hoping to drop to sleep before the itching commenced again. His weight had averaged about one hundred and fifty pounds, but was now reduced to one hundred and twenty-five. The skin around the anus, presented a dry and hard appearance with a few dull white patches. I directed him to bathe the parts frequently while at work during the day with water to which was added a little Borax, and take Sulphur 6x internally.

November 6, 1874, reported that the medicine had given such great relief that he was able to do his spring and summer work in great comfort, but that lately the itching was returning, and he said he had been using the Borax water which seemed to relieve the intensity of the itching, yet he noticed he was gradually getting worse. Gave Sulph. 6x and use Unguentum Zinci oxidi, every evening on going to bed after washing the parts in a solution of Borax, report in ten days, but never heard from him again until April 1875, reported having very little trouble during the winter, but this spring his work had increased the trouble and he was anxious to get relief, continued the Sulphur and Unguentum Zinc oxidi, which he now used faithfully until September, when he reported that he had not felt any itching since June.

Discontinued all medicine and since which time he has remained entirely well to this date, January 1884.

Graphites.—I have found that the field of usefulness for Graphites is limited and is confined to those cases of pruritus, when instead of dry, hard, and leathery appearance of the parts around the anus, there is moisture and tendency to formation of little vesicles, which condition I consider characteristic of Graphites.

(When dry and scaly, Lycopodium. Dry and cracked, tendency to bleed, Nit. acid.)

Other symptoms of Graphites are constipation of hard, knotty stools in lumps united by a thread of mucus, itching in the anus accompanied by the same condition in vulva, worse just before menses, especially adapted to those persons inclined to obesity.

CASE VIII. Mrs. G. M., aged forty-six, a large fleshy woman weighing two hundred and seventy-six pounds, reported July 5, 1875, with great and intense itching and soreness around the anus extending up and including the lower half of vulva, there was a great deal of

moisture between the nates. She had a very profuse leucorrhœa of thin white mucus which was quite offensive. Prescribed Graphites 6x.

July 12, reported being better, continued Graph. August 3, much improved, she continued taking Graph. until October, when she discontinued all medicine. September, 1883, reports no return of the trouble.

Arsenicum has proved beneficial in those cases of broken down constitutions and when thus pruritus seems to be a senile condition; when the itching is more of a burning nature, aggravated by scratching, accompanied by great restlessness, worse from cold applications and cold in general, better from warmth.

Nitric acid is especially indicated in cases with a history of syphilis or scrofula, when the skin around the anus is dry and cracked with tendency to bleed from scratching; sometimes accompanied by anal fissure.

Collinsonia.—Hale (New Remedies page 187,) recommends *Collinsonia* in pruritis ani, and he gives in the key note, the presence of hæmorrhoids, and the same author says, page 286 that Pond's extract of *Hamamelis* will often give relief when used as a wash, but of this I have no experience, preferring the Ung. Zinc oxidi or a solution of Borax or Carbolic acid.

Besides the usual internal remedies to be given, it will often be found necessary to use some local means to control the urgency of the symptoms. The application of a solution of Nitrate of Silver (gr. x— $\bar{3}$ j) with a camel's hair brush on going to bed often gives relief. In some cases Chloroform ointment may be used to great advantage, it produces a smarting sensation at first but that is soon followed by ease. But I have found the greatest benefit in most cases to be derived from the application morning and night of the Benzoated zinc ointment. In those cases where there is a considerable moist secretion, I prefer a weak solution of Carbolic acid or Borax used topically two or three times a day.

CHAPTER V.

PROLAPSUS OF THE RECTUM.

(*Procidentia Recti.*)

A great confusion of ideas has been occasioned by the use of the words *procidentia* and *prolapsus*.

Internal hæmorrhoids, when they have come down outside the anus, are said to be prolapsed, and the case is frequently called *prolapsus ani*; but there is a very marked pathological distinction to be observed between prolapsed internal hæmorrhoids and *prolapsus of the rectum*.

The descent of internal hæmorrhoids is often attended with more or less eversion of the hypertrophied mucous membrane of the lower part of the rectum, similar to what takes place, although in a slighter degree and only temporarily in the ordinary act of defecation. In relaxed states of the sphincter muscle and coats of the bowel, loose folds of mucous membrane alone are liable to protrude and require replacement. This protrusion and exposure of the thickened mucous membrane with or without internal hæmorrhoids, have been erroneously described by writers as *prolapsus of the rectum*. In the true *prolapsus*, however, there is a great deal more than an eversion of the lining membrane of the bowel. The gut is inverted; there is a falling down and protrusion of the whole of the coats—a change in many respects analogous to *intussusception* but differing from it in the circumstance that the involved intestine, instead of being sheathed or invaginated, is uncovered and projects externally.

Varieties.—There is a variety of *procidentia* which one may call *intussusception*, the upper part of the rectum descending through the lower part; this is diagnosticated from ordinary *procidentia* by

there being a more or less deep sulcus around the inner column of the intestine, so that there are, as it were, two cylinders of rectum, one outside the other. This condition is often associated or caused by the growth of a polypus, it gives rise to a train of very distressing symptoms, which may continue long after the removal of the growth which has been the starting point of the malady.

In the adult, it is the descent of the mucous membrane and sub-mucous areolar tissue alone that constitutes the majority of the cases that come under our observation; and this is what we are necessarily led to expect by taking into consideration the firm attachments of the muscles to the surrounding parts, and which, from its function, is also less liable to protrusion than the mucous membrane, this tissue being more voluminous and more loosely connected.

But instances of the descent of the muscular and other tissues are by no means so rare as is generally supposed; in children it constitutes the ordinary form, few cases occurring in early life in which the muscular coat does not descend, and this descension is favored by the formation of the pelvis, the sacrum being nearly straight, moreover, all infants strain violently when their bowels act, even when their motions are quite soft. There appears to be some physiological necessity for this, which I do not pretend to explain or understand; but these facts are quite sufficient to account for the proneness of children to this malady; there is always, in addition, some inherent weakness or extraneous source of irritation present by which excessive straining is caused, we may mention diarrhoea, worms, stone in the bladder, polypus recti, etc. (See Duncan's work on the Diseases of Children.)

There are many cases, however, to which we can assign no special cause when the child is not manifestly unhealthy and no source of irritation can be detected. I am sure that the very bad custom of sitting a child upon the commode and leaving it there for an indefinite period, as practised by many mothers, is a fertile cause of prolapsus.

The causes of the prolapsus in the adult are constitutional and depend upon some peculiarity of the general health or of the habits or occupation of the individual; or they are local, either from disease or irritation existing in the rectum, or as an effect of functional disorder or organic disease in the contiguous pelvic viscera.

In this affection as well as several others to which the rectum is liable,

costiveness is one of the most general causes; the existence of some other rectal disease may produce it, such as hæmorrhoids or polypi; it occurs in close stricture of the intestines, consequent on the straining and violent expulsive efforts attending that disease. Enlargement of the prostate gland is another common local cause in the male subject; it may depend on a relaxation of the sphincter ani, arising simply from muscular debility; inflammation of the bladder in either sex and various diseases of the womb and vagina will likewise produce it.

Women are more prone to the disease than men; but it is found the most frequently in children and in those who are badly nourished or living in close and unhealthy habitations.

Character.—The length of the protruded bowel in prolapsus varies greatly, from an inch to six inches, or even more. The shape and appearance of the swelling depend partly upon its size, and partly upon the condition of the external sphincter.

When not of any great length, the protrusion forms a rounded swelling, which overlaps the anus, at which part it is contracted into a sort of neck. In the centre of the swelling there is a circular opening communicating with the intestinal canal. An inversion of greater extent usually forms an elongated pyriform tumor, the free extremity of which is often tilted forward or to one side, and the intestinal aperture assumes the form of a fissure owing to the traction exerted upon it by the meso-rectum.

In the relaxed condition of the sphincter the surface of the protrusion has the usual florid appearance of the mucous membrane, but in other cases it is of a violet or livid color, and tumid from congestion, the return of the blood being impeded by the contracted sphincter. The exposed mucous membrane is often thickened and granular, and sometimes ulcerated from friction against the thighs and clothes. A thin film of lymph may be occasionally observed coating its surface.

Treatment.—In the treatment we have to consider the removal of the cause, the replacement of the protruded intestine and the retention of it in its natural position as the first and necessary conditions to complete a cure.

In the adult the best mode to secure the replacement of the protruded bowel is to direct the patient to kneel on the bed and rest on his elbows; the buttock being separated by an assistant, the surgeon,

having previously oiled his hands, grasps the tumor and makes firm compression, the patient being directed not to strain, ordinarily the tumor will slip easily within the sphincter. If not reduced by these means, I would recommend the plan of Sir Charles Bell, to cover the finger with oiled paper and then carry the bowel up with it, while the other hand prevents as far as possible the return of the intestine, this oiled paper allows the withdrawal of the finger without bringing down the bowel. If these means fail, by too firm contraction of the sphincter, the patient may be put under the influence of Chloroform, when the obstacle to replacement will probably be removed.

Sometimes when the prolapsus is returned, we find there still remains around the anus a ring of hæmorrhoids. I may here mention that these cases are amongst the most satisfactory to treat, as any treatment applied that will remove the hæmorrhoids will almost certainly cure the prolapsus. Having returned the prolapsus, a pad of lint must be applied and retained with a bandage. The attention must then be turned to the constitutional treatment, and the removal of the cause if known.

The remedies most frequently employed in the treatment of prolapsus ani are, Podophyllum, Sulphur, Ignatia, Nux vomica, and Ruta.

Podophyllum is indicated in those cases of prolapsus where the rectum descends from the least exertion, and where the prolapsus precedes the feces, with early morning aggravation. In children it is more frequently indicated than any other remedy. Other symptoms indicating *Podophyllum* are frequent, large, painless, watery, fetid stools gushing from the rectum. To me the guiding symptom in the choice of this remedy is that the prolapse always takes place before the stools and even in those cases where constipation is present, with feces hard and dry, if accompanied by the above symptom it will always relieve.

Sulphur is found most useful in those cases accompanied by constipation. The stools are hard, knotty and insufficient with frequent ineffectual urging.

CASE IX. The following case will well illustrate its action. Mrs. P. aged twenty-three, mother of four children had been of a costive habit all her life, but in the last three months had noticed her bowel would descend at every stool, often bleeding. After reduction there would be intense itching and stinging in the anus with frequent micturition, tenesmus with feeling that there was more of the stool to

pass, but experience had taught her it was best to lie still a while after stool, and a few hours afterwards take an injection of water. She had periodical attacks of headache with dizziness.

Sulphur was prescribed and in a week she reported herself as free from any prolapse, with but one operation of the bowels since taking the medicine. Did not see her again for over three months, when she reported that soon after commencing the last package of powders she had had regular and healthful passages, without any prolapse. Considered herself well.

Ignatia.—I have never had any benefit from *Ignatia* but in one case, and its action then was so remarkable that I give the case entire, and in the words of the patient.

CASE. X. M——, a young married lady, aged twenty-five, and a mute: "I began to suffer with constipation when thirteen years old, the bowels only relieved once a week. I took a great deal of medicine, but with only temporary relief. After graduating I became a teacher, and taught in a mute school, where I was obliged to go up and down stairs a great deal. I noticed one morning that there was something came down at stool, and was much frightened, but the doctor there told me it was piles, and gave me some medicine which relieved me for awhile, but afterwards it returned, and kept returning at irregular intervals. Teaching disagreed with me. I kept running down in health, had leucorrhœa and great pain every month, when unwell, lost much flesh, and could not sleep nights. The doctors advised me to quit teaching. After that, I got better of everything but this prolapse of the bowel, which would be better for awhile, then worse again. At present, have frequent discharge of large quantity of urine. Am very nervous and afraid of doctors, for one told me I must have piece of bowel cut out. After my marriage my leucorrhœa returned, and I have palpitation of the heart, do not sleep well at night, and wake up very tired. The slightest exertion causes fatigue; stools are now hard, small and round."

I prescribed, at different times, *Podophyllum*, *Sulphur*, *Lycopodium*, etc., with little benefit. Under *Ignatia* there was rapid improvement of all her symptoms. After taking the medicine ten days, had no more prolapse.

Nux vomica will be found useful in prolapsus accompanied by constipation, with frequent, ineffectual desire for stool. *Feces* large, hard, dark, and often streaked with blood. It is indicated where the patient has been taking all kinds of drug mixtures. Useful in bad effects from highly seasoned food, coffee, and spirituous liquors.

Ruta graveolens.—Of this remedy I have no experience, but the following, from Hoyne's Clinical Therapeutics, will well illustrate its action :

CASE XI. Mr. N—, aged twenty-seven, nervous temperament, dark hair, blue eyes ; has been troubled with prolapsus for years. It is a family complaint. Has frequent, lumpy, slimy stools, at times bloody ; much flatus ; stools often unsatisfactory, passing nothing but flatus ; empty eructation and distended abdomen. Feces often escape while bending over. Weakness in lumbar region ; frequent urination ; prolapsus always occurs when at stool, and at times without stool ; usually has four or five stools a day. Ruta, 200, one powder every morning, cured.

Arnica is recommended by Prof. R. Hughes. There is one case in the fifth volume of the *British Journal of Homœopathy* in which *Arnica* in mother tincture cured.

Other remedies are *Lycopodium*, *Mercurius*, *Arsenicum*, *Calcarea carbonica*.

CHAPTER VI.

POLYPUS OF THE RECTUM.

The rectum like all other mucous surfaces, viz., vagina, nose, etc., is occasionally affected with polypus. By the word "*polypus*" I must be understood to mean a pedunculated growth attached to the mucous membrane of the rectum and generally not less than an inch from the anus.

It is rather an uncommon disease, and is found more frequently in children than in adults, at least that is the experience of most writers on the subject. With myself, it has never been my fortune to meet but three cases and they were in persons above the age of twenty-five, and all of one variety.

Varieties.—Polypi has usually been described as two kinds, the soft or follicular and the hard or fibrous.

Dr. Allingham says the former occurs in children and the latter in grown persons, this coincides with my experience, as my cases were all in grown persons and all of the fibrous variety.

The follicular polypus usually makes its appearance after a stool resembling a small strawberry, being of soft texture, granular on its surface, and of a red color, varying in size from a pea to a walnut, the pedicle is generally about one and one-half inches long and rooted just above the sphincter. They bleed very freely at times and occasion in the young great debility. When the pedicle is more than an inch in length, they usually protrude at stool, and require to be returned after the bowels are relieved.

The child's mother is very apt to describe them as piles or "falling of the bowel;" the real nature of the complaint can usually be detected by the introduction of the finger, but it sometimes happens, owing to the polypus being very movable that it passes up the bowel and gets out of reach.

The treatment of polypus in children is very simple and always effectual. The tumor should be strangulated by a ligature secured around the pedicle and then returned within the bowel, it is unnecessary to cut off the pedicle after ligating it, as the polypus will separate in two or three days and come away.

A polypus should not be excised without ligating, as dangerous bleeding is likely to occur. This once happened in a case operated upon by Sir A. Cooper, to such an extent as to occasion alarm.

I can find no record of any cases of polypi of the rectum being treated and cured by Homœopathic remedies, but if any one desires to try remedies I would have more confidence in the efficacy of one of the following: Calcarea carb., Lycopodium, Phosphorus, Silicea, Teucrium and Thuya.

THE FIBROUS POLYPUS.

The fibrous polypus occurs more often in the adult. It generally originates in hypertrophy of the sub-mucous areolar tissue, and is generally smaller than the mucous polypus of children. Persons who suffer with rectal polypi generally experience a sense of weight and uneasiness in the lower part of the pelvis, with a frequent desire to relieve the bowels, with more or less straining during stool. The feces are usually somewhat flattened, and there is almost always an abundant discharge of mucus of a glairy, reddish appearance, not unlike thin currant jelly. Polypi are often complicated with abscesses, fistulæ ulcers or fissure.

CASE XII. J. H., aged forty-seven, May 5, 1878, came to me complaining of great pain after stool, with falling of the bowel. This falling of the bowel had existed at intervals for about three years, but the pain after stool was of recent origin. Upon examination I detected a fissure and set the next day for the operation, which gave him relief from pain for a couple of weeks. But the pain returned as severe as ever. Examined again and on requesting him to strain, he brought down what I supposed at first to be an internal hæmorrhoid, but on further inspection found it to be a polypus. I applied a ligature immediately and concluded to let the fissure alone until some other day. The polypus came away on the fourth day and as the fissure was giving him no pain and seemed to be healing, I let it alone and in two weeks it was entirely healed.

The *diagnosis* of polypus is usually not difficult. Its tardy growth; occasional protrusion at the anus, and the functional disturbance which it causes in the bowel, with its occasional hæmorrhages are generally sufficiently characteristic, but all doubt will be dispelled by

a digital examination which should be made only after an injection has been administered. It will then be always possible to feel it or see it. If it be one of those with a very long pedicle, its attachment can be felt.

It is possible to mistake this disease for internal piles, prolapsus, or dysentery ; an examination will clear up the first two points and the absence of fever, and the appearance of the stool will settle the last.

CASE XIII. C.W.D., aged twenty-eight, Rock Island, Ill., occupation, civil engineer, was sent to me by my friend, Dr. Lawrence, in the fall of 1875. An examination revealed a fibrous polypus, about the size of a chestnut, with an attachment to the posterior surface of rectum, just above the internal sphincter, with a pedicle about one and one-half inches long, protruding at every stool, also when coughing or loud laughing.

I used a bivalve speculum, and ligated the pedicle as high as I could reach, and cut off the tumor. He went home the same day. Reported in February 1876 that the operation gave immediate relief and that he had no farther trouble.

I cannot explain why these growths should arise. They are not often connected with hæmorrhoids or any other disease of the rectum save fissure.

I have not observed that constipation, even, that potent factor of bowel affections, is a common accompaniment in these cases.

As I stated before, I have no experience with remedies in the cure of those cases, as the ligature has been such a quick, easy and certain mode of cure. I have not been tempted even to try anything else.

CHAPTER VII.

HÆMORRHOIDS OR PILES.

EXTERNAL HÆMORRHOIDS.

Hæmorrhoids or piles are terms used by which we understand a certain kind of tumors occurring at the verge of the anus or within the rectum. They acquire great importance and demand the careful attention of the practitioner, in consequence of their great frequency and the immense amount of suffering and the great discomfort they produce, as well as from the great benefit and perfect relief obtained by appropriate treatment.

Varieties.—From as early a period in the history of medicine as we are able to trace, hæmorrhoids have been divided into two varieties, external and internal, and this classification is founded upon a true pathological distinction.

Pathology.—The ancient physicians from a defective knowledge of anatomy and pathology were unacquainted with the true nature of these affections, and held very erroneous opinions of the structure of the tumors forming hæmorrhoids; they entertained the notion that they performed the function of evacuating black bile and melancholic humors from the system. After the discovery of the circulation by Harvey, a new but equally erroneous theory was generally received, it being conceived that bleeding from external piles depleted the system generally, and that hæmorrhage from internal piles depleted the portal system only. By later and even recent authors, hæmorrhoids are considered to be varices, and analogous to that condition of the spermatic veins, constituting varicocele, and to the dilatation of the superficial veins of the legs which cause so much distress and so often give rise to very troublesome ulceration. These two varieties of

hæmorrhoids (external and internal) differ in their situation, in their structure, and also in regard to the treatment required for their relief.

The more common variety of the two is the *external hæmorrhoid*. It consists essentially in an extravasation of blood into the cellular tissue of the part caused by a rupture of a hæmorrhoidal vein, the tumor being covered wholly by skin, or partly skin and partly by mucous membrane. As the effused blood always speedily coagulates, the tumor soon becomes hard, firm and inelastic, its contents rolling out, after an incision, as a solid mass of a dark purple color and without any admixture of serum. The pouch in which the blood is contained is usually composed in part, of the ruptured coats of the vein, the remainder being formed, as already stated, by the connecting areolar tissue, the cells of which are speedily closed by plastic matter.

It is the opinion of a great many physicians that external piles are formed by the distension of a loop of a hæmorrhoidal vein, but I do not think that to be the case, for the following reasons: It is not the nature of veins to contract even when they have been slightly dilated, and we frequently observe external tumors subside and the tissues assume a normal condition. Further, when these tumors are incised, the blood is turned out as a clot; or if fluid, it is not at all commensurate in quantity with that which would flow from a dilated and congested vein.

Etiology.—There is no doubt that some occupations and modes of life tend to the productions of external hæmorrhoids, yet this affection is so prevalent that few persons either male or female arrive at middle age without having in some degree suffered with it. They occur in the rich and the poor; in the robust and the weakly; in those of active as well as sedentary life. They are supposed to be caused by certain anatomical peculiarities of structure in the rectum and its veins; obstructions of the liver or portal system, fecal accumulations, indeed anything rendering the return of blood from the rectum difficult, is likely to conduce to the same end.

From this we can readily imagine that a great variety of causes may bring on an attack of piles; of which a few may be mentioned, constipation often associated with chronic spasm of external sphincter muscle, diarrhœa, (indeed most of the cases of external piles that have fallen under my observation have arisen during an attack of diarrhœa,) sedentary occupation, uterine displacement, pregnancy, and straining, however induced.

SANGUINEOUS TUMORS.

Most authors describe two varieties of *external hæmorrhoids*, viz : 1st, a sanguineous venous tumor. 2d, cutaneous excrescence or outgrowth.

Appearance.—When you look at either of these in an uninfamed state, you would think them harmless enough; in the one case you would perceive veins, blue, rather raised above the surface, resembling a varicose vein; in the other you would observe around the anal orifice a certain redundancy of the skin, forming little flaps or tabs more or less pendulous, in addition to the small radiating corrugations seen in the normal state. Now these conditions, so innocent in appearance, are prone, at a trifling provocation, to take on active inflammation and to cause the patient an amount of suffering quite out of proportion to the pathological appearance.

Let us look at, them when inflammation, set up by any of the causes we have before mentioned, has set in. These small tabs of skin are increased in size; they may be very much swollen, œdematous and slimy; exceedingly painful to the touch. Sometimes they ulcerate, or suppuration may take place if the inflammation runs very high, hence small but painful little fistulæ arise. (See article on fistula.) At times the œdema is so considerable as to extend into the bowel, and form a large swollen ring of skin and everted mucous membrane all around the anus.

So with regard to the sanguineous venous tumors. They are swollen into ovoid or globular bluish tumors, very hard and exquisitely painful. When pinched up between the finger and thumb, from the tissues beneath, they feel as if a foreign body were present there.

These tumors may be single, or two or three may be present at the same time. By irritation they set up spasm of the sphincter and levator-ani muscles, so that they are drawn up and pinched, thus adding much to the patient's suffering. Just as he is falling asleep, a spasm takes place, and wakes him up. In addition, there is a constant throbbing, and a sensation as if a foreign body were thrust into the anus; this excites the desire, every now and then, to attempt to expel it by straining, which, if indulged in, of course aggravates the pain. Often, the patient cannot sit down, save in a constrained attitude, nor can he walk, and when he coughs the sensation causes acute suffering. When the bowels act, and for some hours afterwards, the

distress is greatly increased, and the patient, if not absolutely confined to bed, is quite incapable of attending to his business. Accompanying all this, there is general feverishness, furred tongue, and usually constipation.

Such, then, are the symptoms of an acute attack of external piles, and if not a serious matter, it is one causing great worry and loss of time—an important point in these hard working days. Moreover, one invasion predisposes to another.

Treatment.—In the treatment of external hæmorrhoids, it is very desirable to notice the premonitory symptoms of one of these attacks, as by this knowledge it may possibly be warded off, or at all events, much mitigated. The earliest symptom is a sensation of fullness, and dragging or plugging up, and a slight pulsation in the anus. There is often a slight diarrhœa, which induces a great deal of straining; in some cases, we find constipation. If the patient be a very observing person, he will notice after a motion, a slight show of blood, and the anus will be a little swollen and tender. Now all this may pass off with the simplest care, and the slightest medication; but if the patient neglect himself and seek no advice until active inflammation has set in, and the symptoms described above are in full force, you will save your patient much time, pain and often trouble by snipping off the inflamed cutaneous excrescences; or in the case of the sanguineous tumors, by laying them freely open, and turning out the clot.

The tabs of skin may be seized with a pair of forceps, and snipped off with a pair of strong scissors. The pain soon ceases, and the wound heals kindly under any simple dressing. The physician should be careful not to recklessly cut away too much skin by making a clean sweep of it, but take off a small portion only. The remaining portion will contract in the process of healing.

The best mode of opening the venous tumor is to transfix the tumor at a point nearest the anus with a curved bistoury, and cut out. And here let me give this direction in regard to the use of the knife in the region of the anus: *All incisions should radiate from the anus as a centre.* The reason for this is, you avoid cutting across the general course of any of the blood vessels in this region, and escape the possible effects of subsequent contraction in healing. (See organic contraction of the anus.)

After the incision is made and the clot turned out, I have found that

the best mode to dress the wound is, to take a small piece of cotton, smeared with Cosmoline, and lay it in the sack, with a small portion projecting out. This is to be removed the next day. The pain from the operation soon subsides, and the patient will make a speedy convalescence.

CASE XIV. J. D., aged thirty-five, sent for me September 20, 1875, to come to the house, where I found him in bed, unable to get up, he had two external hæmorrhoids one on each side, and every motion was very painful, both being in an active state of inflammation. He had been troubled with attacks like this about every three or four months for fifteen years. I immediately laid open both of the tumors turning out large clots, and in an hour he was at his work, (wagon making) and to this time has had no further trouble.

CASE XV. C. L. aged thirty-three, February 24, 1879, presented himself with the following history: The week previous was troubled with a slight diarrhoea caused as he said by errors of diet and in the night while at stool, he felt something give away, but gave him no pain. The next morning he noticed slight soreness and some swelling at the verge of the anus, which had increased from day to day, until to-day he had given up business to seek relief, his bowels were now costive and on moving this morning gave severe pain which has not passed away yet, there is throbbing beating in the anus with burning, much increased by exercise, stools large, hard, dry and streaked with blood, frequent desire to go to stool, he feels better by wearing a pad that presses up against the tumor.

Examination revealed a single blue sanguineous tumor on left side of anus, highly inflamed. Has had several attacks like this before, the last three months, from which he was obliged to lose over two weeks away from business. He says "if you have anything or can do anything to give relief, go ahead." I immediately incised the tumor and turned out a black clot as large as a filbert. I then placed in the sack a piece of cotton smeared with Cosmoline, and gave Nux vom. 8x to control constipation. Told him to go about his business as usual and report next day.

February 25, returned reporting having been perfectly free from pain since operation and from then till this time (1888) he has never had any further trouble.

Although the above is the treatment I would recommend, yet you will find patients who will not submit to any operative interference, and to these we can say that Homœopathy possesses medicines that in a great majority of cases render unnecessary the knife, ligature, or caustic. In such cases I always prescribe one of the remedies recommended below, and use locally an ointment of the

extract of Belladonna and Opium, equal parts, with warm poultices or cold applications—the one which seems to be the most soothing to the patient.

Some authors insist that the inflammation should be reduced before incising the tumors. I do not think there is any need of this, for it is my experience that there is no danger in any way if the operation be properly performed. And I am further convinced that convalescence is much retarded by waiting till the inflammation has subsided before operative interference.

I have said that one attack of external piles predisposes to another; it is therefore necessary so to live as to ward off, if possible, this repetition.

If the attack was originally accompanied by diarrhoea, it will be necessary to so guard his diet that diarrhoea will not take place; if accompanied by constipation, he should select his diet so as to have the bowels move daily. (See constipation.) Pills and all laxative medicines are to be avoided, and if any means are necessary to move the bowels, a simple injection of warm water and soap will answer the purpose.

Of all the different remedies recommended by our school, I have never found it necessary to go beyond Aloes, Nux, Podophyllum, Sulphur, Hamamelis, *Æsculus hipp.* and Arsenicum.

Æsculus Hipp.—The indications for this remedy are: piles always accompanied by constipation; stools large, dry, hard, and difficult to pass; no bleeding. Always with aching pain and lameness across lumbo-sacral region, affecting sacrum and hips; pains worse by exercise. Dryness, heat and constriction of the rectum; rectum feels as if full of sticks. [Dr. Hart's special indication for its use is throbbing in the abdominal and pelvic cavities.]

CASE XVI. Mrs. G. S., aged thirty-two, married, with one child, says that since her confinement, two years previous, she has been troubled with piles. The tumor being constantly present outside the sphincter, from its position producing frequent and urgent desire for stool, passing with difficulty, aching in the back and through the hips all the time; occasionally the pile would seem to inflame from slight causes and become very sore and painful. She had used all the patent medicines that she could find recommended, with no permanent good.

She sent for me April 7, 1878, to see if I could give her relief as the piles were now giving her a great deal of pain. I found one dark

purple tumor on left side of anus, mostly covered by skin, but seemed to be grasped by sphincter muscle. She gave me to understand the first thing that no cutting should be done.

Gave *Æsculus hipp.* 2x, twenty drops in one-half glass of water, teaspoonful every three hours during the day.

April 10, soreness mostly gone, but tumor same size.

April 21, no change, could tell no difference in size of tumor.

May 20, sent for me, piles very sore and painful, caused by riding in a wagon. Arn. 2x to be given four days then *Æsculus* as before.

May 26, soreness gone.

June 22, reported much better, and to-day was the first in which I felt satisfied the tumor had decreased in size.

From this time till September, she continued taking *Æsculus* at which time she reported her condition, much improved, no soreness, no sensation of plug in anus, and I found only a small tab of skin remaining; advised her to have that removed, but she declined. Since that time have heard nothing from her, and am satisfied I should have heard, if she had had any more trouble.

Aloes.—Protruding piles, like bunches of grapes, with constant bearing down in the rectum, always accompanied by diarrhœa; stools small, brownish, slimy, half filled with jelly-like mucous tinged with blood; much sputtering of flatus; feces often escape without being noticed, seeming like paralysis of sphincter ani. Better from applying cold water. When urinating has feeling as though some liquid discharge from the bowels would or had taken place at the same time. Constant rumbling in the abdomen, as though he must have stool, but no evacuations follow the effort.

CASE XVII. *Capillary Hæmorrhoids.*—B. W. A., aged thirty-one, a merchant who was on his feet constantly, from morning till night, was troubled with diarrhœa and sensation of foreign body within the sphincter, with constant bearing down, with heat and burning in the anus, and passing blood at every stool. There were two small tumors situated on same side, that were protruded without much difficulty, and looked like very small ripe raspberries. *Aloes* 3x stopped the hæmorrhage in a week, and the tumors were entirely gone in three months.

Hamamelis virg.—Piles bleeding profusely at every stool, burning soreness, fullness and weight in the rectum; at times, rawness of the anus. The back feels as if it would break.

Piles may or may not protrude, but when they protrude, the remedy is more successful.

Bleeding is the key-note; Ham. is used empirically as a pronounced topical remedy, and very successful.

Arsenicum album.—Piles which burn like fire, particularly at night, when walking and sitting; better when at stool. Anus red and sore. The rectum is pushed out spasmodically, with great pain, and remains protruded after hæmorrhage from the rectum.

Diarrhœa of slimy, green mucus, watery; always after drinking, or eating soup, immediate discharge from the bowels, as though the fluids were rolled through without stopping.

Podophyllum.—Internal piles, when accompanied by prolapsus of the bowel, and with diarrhœa; frequent, painless, watery discharge, gushing out (also *Croton tig.*) worse always in the mornings.

Constipation, with flatulence and headache; feces hard and dry, and voided with difficulty.

Morning aggravation is characteristic of *Podophyllum*.

CUTANEOUS TUMORS.

The second form of external piles consists of a flattened prolongation of skin. They are generally the chronic result of the first form, a projecting fold left after absorption of the coagulum having undergone further growth.

The cutaneous excrescences contain no clots, and no enlarged or varicose veins, but clots and dilated veins may often be found at their base.

There is sometimes only a single broad, flat excrescence at the side of the anus, but there are often two, one on each side and occasionally more.

Similar excrescences occur as the result of irritating discharges from the bowel, and are common in stricture and ulceration of the rectum.

Treatment.—I have never found any treatment satisfactory in these cutaneous excrescences, except snipping off the superabundant tissue, and here I cannot be too particular in warning you *not to cut too much*, for in healing it will shrink very considerably, and if not very careful you will have a constriction of the anal orifice.

CHAPTER VIII.

INTERNAL HÆMORRHOIDS.

Internal hæmorrhoids or bleeding piles, as they are sometimes called, constitute a disease which is much more serious than the external variety. It is more insidious in its approach and more persistent in its character. It tends to undermine the general health of the sufferer, and in extreme cases to place even life in danger.

Causes.—All those causes that I have mentioned as likely to induce external hæmorrhoids, tend also to the production of the internal variety. There is a network of good sized veins surrounding the lower end of the rectum, for an inch or two, in the rather abundant connective tissue between its mucous membrane and the layer of circular muscular fibres surrounding it, which is known as the *hæmorrhoidal plexus*, and that the veins immediately around the verge of the anus form a continuous network by anastomosis with the hæmorrhoidal plexus within, and these veins anastomose even in the substance of the sphincter muscle.

Now it is a remarkable fact that none of these veins are provided with valves, and consequently whenever the abdominal circulation is obstructed, there is a strong tendency to stagnation in its lowermost tributaries, hence the hæmorrhoidal veins are often found in a state of varicose enlargement, with thickened walls and pouch-like dilatations.

Such is the common explanation of the cause of hæmorrhoids, but the French physicians for a long time past have not been satisfied with this explanation of the etiology of piles; they do not consider that any causes which are occasional can induce such an afflux and stasis of blood in the rectal veins as shall be productive of hæmorrhoids.

Neither, say they, sedentary occupation, excesses at the table, venereal abuses, the immoderate and prolonged use of enemata, drastic purgatives, nor habitual and severe constipation can one or all initiate true hæmorrhoids. They therefore with praiseworthy diligence, sought for the true predisposing cause in the anatomy and physiology of the rectum.

Pathology.—Professor Verneuil, the distinguished Parisian surgeon, says he has discovered that cause in the peculiar distribution of the veins and the course they take in the coats of the rectum a few inches above the anus. The preparations and dissections made to illustrate and prove his views are now in the Dupuytren museum at Paris; and the correctness of the anatomy, and the deductions made from it, have, says recent French authors, not only been confirmed, but even proved by the dissections of Gosselin, in 1864. Dubreuil and Richard, in 1868, and lastly by Duret, in 1877.

I shall endeavor, as briefly as I possibly can, to place before my readers the anatomy as stated by M. Verneuil, because it is considered to give the reasons for a method of treating hæmorrhoids strongly advocated in France; but, as far as I know, little practised in America and England; (and from it we can explain why the recent American mode of treating piles by injections is so successful.)

1. Professor Verneuil considers that the superior hæmorrhoidal veins *only* are connected with the portal system and solely form internal hæmorrhoids; external piles being formed from the middle and external hæmorrhoidal which are connected with the general venous system, and do not, or only in the most remote degree, form connections with the superior hæmorrhoidal veins, and thus the two venous systems, portal and general are practically distinct.

2. That the superior hæmorrhoidal veins commence at the upper border of the external sphincter, and lie under the mucous membrane of the rectum. At a definite height of about four inches they perforate abruptly the muscular coats of the bowel, and unite to form the five or six large veins found in the meso-rectum, these then join the inferior mesenteric veins, which pass into the splenic and portal veins and thus into the liver.

3. When the superior hæmorrhoidal veins perforate the wall of the rectum, Verneuil claims to have discovered that they pass through "veritables boutonnières musculaires," which muscular button-holes not being surrounded by any protective fibroid tissue, have the power

of contracting and causing such stasis and congestion in the superior hæmorrhoidal veins as to constitute the "primum mobile" in the formation of internal piles.

Dubreuil further calls attention to the fact, that the muscular button-holes are double and at right angles to each other, the first being formed by the circular fibres, and the second by the longitudinal fibres of the rectum, not only, says Verneuil, do these contractile button-holes constitute the passive, but also the active cause of hæmorrhoids, any intestinal irritation will produce violent and spasmodic contractions of the muscular apertures, these contractions are communicated to the levator and sphincter ani muscles, and a rapid development of internal hæmorrhoids will take place. Commonly in addition, those occasional causes (formerly considered as first cause) come into play, and the small varicosities found at the lower border of the internal sphincter (present even in infants, say the French) soon become fully formed piles. The practical outcome, from the above anatomy and physiology by the French authors, is very important, viz : that for the cure of the great majority of internal hæmorrhoids, nothing is required but the gentle and thorough dilatation of the external and internal sphincter muscles, no ligatures, no cautery with or without clamp, is wanted and no immediate removal of the piles need take place.

The anatomy of the rectum, given by M. Verneuil, has been known for many years, but only recently (in 1874) has the practice of dilatation been recommended for the cure of hæmorrhoids by that gentleman, and it appears to me that the discovery of that treatment was rather the result of accident than reflection and deduction from any known anatomy and physiology. The case which opened the eyes of Professor Verneuil to the advantage of dilatation is thus related by him.

CASE XVIII. I was consulted by a distinguished gentleman who had for fourteen years suffered anal pains supposed to be caused by fissure, but they in reality were caused by internal hæmorrhoids which had become procident and irreducible; with this state not only had the patient's pains been redoubled, but he suffered such loss of blood as to bring him near to death; his anæmia was so profound that I considered the usual operative methods too dangerous to be undertaken, and as the sphincters were very contracted I contented myself by dilating them, and from that day the pain and loss of blood ceased the piles were cured and did not return. Encouraged by this happy experiment," says M. Verneuil, "I hastened to put it into practice in other cases with excellent results."

M. Fontan, a little later, not knowing, I presume, of M. Verneuil's success, also accidentally discovered that forcible dilatation of the sphincters cured hæmorrhoids; for says he, having dilated the muscles for the purpose of curing a fissure in a patient who also suffered with hæmorrhoids (June 1875,) I found with the cessation of the symptoms of the fissure, disappeared also the hæmorrhoids, the constipation, the daily bleeding, and the prolapsus, and I was struck by this unhopèd for result. (Vide Fontan on the Cure of Hæmorrhoids by Forcible Dilatation, Paris, 1877.)

It would be presumptuous in me to dispute the anatomical facts set forth by Professor Verneuil and endorsed by such men as Gosselin, Dubreuil, Duret, and others; indeed the dissections that I have been able to make, induce me to concur in the main points set forth by the learned professor; but with all due deference, I cannot admit, as a fact, the almost absolute separation of the portal and general venous system. I am quite confident that in the dissections of morbid specimens, near the anus, you do find a considerable communication between the superior, inferior and middle hæmorrhoidal veins. One fallacy I would suggest, arises in M. Verneuil's physiology, from the fact of his having injected the superior hæmorrhoidal veins from the portal vein, thus forcing the injection in a direction opposed to the natural flow of the stream of blood. Again, admitting the correctness of the presence of the "button-hole" apertures through the muscular walls of the rectum, I should demur as to the deductions made by M. Verneuil, that they cause by contraction an obstacle to the return of blood from the lower portion of the rectum; and on the contrary I should infer that these contractile apertures really play the part of valves to support the column of blood to the liver, and in place of causing stasis, prevent it by opposing regurgitation in congested states of that organ and I would rather, in accordance with general physiological principles infer, that the contraction of the circular and longitudinal muscular fibres of the bowel favor, and do not retard the upward flow of the blood; and I am not convinced, whatever may be the value of dilatation of the sphincters in treatment that the theory of M. Verneuil explains in a wholly satisfactory manner the causes and pathology of hæmorrhoids. One more point I would mention. In Professor Verneuil's thesis he makes no allusion to the part played by the arteries in the formation of piles, yet I should think no one could fail to note that hæmorrhoids are not merely varicosities, but tumors, into the structure of which considerable arteries enter.

Varieties.—In structure, internal hæmorrhoids present three principal varieties. The first consists of loose folds of mucous membrane, with thickening of the submucous tissue and with the capillaries increased in number and size. When these tumors are prolapsed they present a deep red, velvety appearance, which bleed very readily, and the blood is generally arterial in character.

The second form, the tumors are more solid, nearly round, and have a smooth dull surface sometimes a portion of these tumors have the same anatomical structure as the first variety, in such cases hæmorrhages may occur, otherwise loss of blood does not take place.

The third variety will be more clearly indicated by the term vascular excrescence, it being a florid excessively vascular granular condition of the mucous membrane, it is in these cases that the hæmorrhage is a permanent symptom.

Some of these tumors lie quietly within the internal sphincter and are only protruded by violent efforts at straining, others come down always at stool and whenever the patient makes any exertion or stoops or walks much, these various conditions depending in a great measure upon the duration of the disease and the strength of the sphincter muscles.

Size.—Internal hæmorrhoids vary much in size and number as well as in amount of pain and hæmorrhage. They may be so small as to exhibit little more than an increased number and size of capillaries, or they may be large solid tumors the size of a walnut.

Symptoms.—A hæmorrhoidal tumor, situated near the verge of the anus, will be very liable to be prolapsed at stool, thus giving rise to pain, spasm of the sphincter, and other distressing symptoms. Those that are situated higher in the bowel are not prolapsed so early in the disease; but by the repeated irritation and dragging down they experience during the time the feces are being evacuated, they become elongated, and at length protrude externally. At first they readily return within the sphincter, but after a time the patient is obliged to replace them with his fingers. In some cases, this is done with facility, but in others greater difficulty is experienced, owing either to the size of the tumors, or to their being constricted by the sphincter muscle. In many cases, when the tumors are large and numerous, and have been subject to prolapse for a length of time, the sphincter and tissues of the anus lose their tone, are much relaxed, and the

patient is subject to constant annoyance by their protrusion whenever he attempts to walk or ride or stoop ; nor is the prolapse confined to the tumor alone, for the bowel having lost its support, is easily dragged down by these morbid growths, and the expulsive efforts at stool.

So great is the suffering, and so annoying to the patient is this constant protrusion from slight causes, that the patient is induced to postpone the call of nature till evening ; as he has probably found by experience that on those days in which he has had no movement of the bowels, his suffering has been much less. By attending to his operations in the evening, he can lie down for awhile, and finds it much easier to return the tumors while he is in a horizontal position, in which he also experiences more speedy relief from pain.

As a rule, patients do not suffer much pain from internal hæmorrhoids, unless they are constantly coming down and getting compressed by the sphincter, or become inflamed from any cause.

Hæmorrhage is a prominent symptom in internal piles, for when the tumors come down, they nearly always bleed, and this flow only ceases upon the return of the tumors within the sphincter.

Complications.—The symptoms produced by internal hæmorrhoids are not always confined to the seat of disease. Irritation frequently extends to the urinary organs, the patient being occasionally troubled with a frequent desire to pass water, and even with difficulty in voiding it. On the other hand, disease of the urinary organs is a very common cause of hæmorrhoids. The connection between piles and disease of the urinary organs is a matter of considerable importance ; and the surgeon should be careful to ascertain the original and chief source of the patient's sufferings. Persons with stricture of the urethra, stone in the bladder, or enlargement of the prostate gland, are accustomed to strain so much in passing water that they are frequently unable to empty the bladder without at the same time relieving the rectum. After the cure of the stricture in the urethra, or the removal of the stone from the bladder, the inconvenience suffered from the hæmorrhoids often ceases without any treatment directed to the latter complaint. Owing to the close relation of the uterus to the rectum, many of the diseases of the former organ have an injurious effect upon the latter. Women usually suffer more from piles during the catamenia than at other periods.

TREATMENT OF INTERNAL HÆMORRHOIDS.

Treatment.—It sometimes happens that when internal piles protrude at the anus, and are severely strangled by the external sphincter, that they slough off, the patient being relieved of a serious complaint by a sort of natural process; an occurrence entirely free from danger, but attended by a great deal of pain and suffering.

The treatment of this very common and most distressing malady is best considered under two different heads, medical and surgical.

Medical.—The surgeon, however successful he may be in the radical treatment of piles, and in spite of all that he may say to his patient, of the advantage of a surgical treatment, he will still have many more chances in the way of medical treatment than will fall to him under the surgical head.

It is therefore of great advantage to know what can be done for a timid and reluctant sufferer, without the knife, ligature or caustic; and indeed it cannot be too widely or too clearly known that Homœopathy possesses medicines which, if properly used, will make all patients with internal piles more comfortable, and cure, in the great majority of cases. And it might claim the gratitude of mankind, on this alone, if it had done nothing else for the healing art.

Of all remedies for the control of this complaint, my experience places Nux and Sulphur at the head.

I will admit that the impediment to the circulation, of which piles are a symptom, does sometimes consist of an engorged liver, and that a remedy which is applied to relieve this engorgement will cure the hæmorrhoids, yet generally it is only necessary to take into consideration the totality of symptoms presented in each case, and that will decide the remedy.

Nux and Sulphur seem to act better conjointly (in alternation) than when either is given separately, and it is in the “abdominal plethora” of the old writers, showing itself by weight, fulness and heat in the bowels, slow digestion, delayed stools, and scanty and pale urine, and in all those cases where purgative medicines have been used extensively; where the person has been addicted to the use of liquors, spices, coffee, etc.; constipation, with stools difficult to pass, burning and pressure in the rectum during a stool, with frequent ineffectual urging. Indeed I have found it very beneficial to commence the treatment in the majority of cases with Nux and Sulphur.

Aloes.—For hæmorrhoids in women with pelvic congestion, the truly Homœopathic remedy is Aloes.

But it has of late found a rival in *Collinsonia*. The latter has obtained its reputation in cases of congestive inertia of the rectum.

With Aloes we find that heat, pressing and burning in the rectum, with the tumors protruding like a bunch of grapes, are very sore, painful and tender to touch, and is especially useful in those cases where there seems to be a relaxation of the sphincter ani, the patient being afraid to attempt to pass wind on account of a little, thin, brownish, watery, offensive stool escaping.

CASE XIX. Nine days after confinement, Mrs. L. C. sent to me for relief from an attack of piles coming on immediately after confinement and getting worse daily, pain in back all the time, severe burning, pain in rectum lasting two hours after every evacuation. She had been using twice daily an injection of warm water, which afforded much relief, much worse at night, declared she had not slept any since her child was born.

Gave Graphites, supposing it was a case of fissure, sent for me the next day being no better, when I obtained the following additional symptoms: Tumors protruding and were very sore, seemed to be grasped by the sphincter like a vice, yet there was a lack of control of the muscle, for at every effort there was an oozing of thin fecal matter from the bowel. Aloes relieved in a few hours and in three days was as well as usual at such times.

I was much in doubt in this case whether to prescribe Aloes or *Æsculus*, but better by warmth and worse at night decided me in my choice.

This case had sent for me expecting to submit to an operation, as her physician told her nothing but an operation would relieve. As a result, made her a firm convert to Homœopathy.

Hepar sulphuris will be indicated when the clay colored stools are present and in those cases where there are obstruction to the abdominal venous circulation giving great distress to the patient, prevent in the abdominal respiration and producing oppression of breathing, it will also be found very useful in those cases where there seems to be ulcers in the rectum in connection with piles.

Podophyllum, like *Hepar* is especially useful in those cases where there is a chronic engorgement of the liver, where there is a great tendency to prolapse of the rectum, and here I might give what is my key note for the use of *Pod.* in prolapsus, that is the prolapse always occurs before the stool.

Æsculus has been very serviceable in piles of very recent growth where they seem to be produced by an attack of constipation which has lasted only a few days. The symptoms which guide me in the choice of *Æsculus* are constipation, aching pain in the lumbo-sacra region, and the piles are of the bleeding variety, and I can say *Æsculus* has never failed me where those symptoms were all present.

CASE XX. Mrs. W. R., aged forty-two, had been subject for a great many years to attacks of piles upon becoming the least costive. Would not bleed, but she said it felt to her as if her whole bowel turned out; severe pain in the back, always worse on the least motion, if these attacks came at the time of her catamenia, they were much worse and she could not get out of bed for a week. Wanted something to prevent return of paroxysm. Prescribed Nux and Sulphur with some relief, but after continuing for three months, and having two severe spells, although she said they were not quite as bad as the average, I was much dissatisfied, and gave *Æsculus* 2x and she has had no return of piles or constipation for over two years.

Muriatic acid has been highly recommended in those cases where the piles are very large and are very painful to the touch, but of this I have had no experience and can only say if I had such a case would try it.

Hamamelis is especially suited to the hæmorrhagic variety of piles. I have repeatedly cured case after case of "bleeding piles" by *Hamamelis* internally, and I know of no remedy that is so certain in its results when properly indicated.

CASE XXI. Mr. Ed. D., was attacked with piles first during the summer of 1875, but did not give much annoyance until the fall of 1879, when they commenced to bleed at every stool, and had continued to flow freely up to this time, February, 1880. Is now very anæmic, unable to do any work on account of extreme prostration. Complains of considerable pain in back and loins, repeated attacks of headache confined to left side of head. He took *Hamamelis* tincture two drops three times a day. In April reported himself very much better, he moved to Nebraska the same spring and in September, 1883, in answer to a letter said he never had any further trouble.

SURGICAL TREATMENT OF INTERNAL HÆMORRHOIDS.

When you have determined that there is no constitutional impediment to the use of surgical measures, I know of no operation in surgery, that will reflect as much credit upon the surgeon and give more satisfaction to the patient than the removal of internal hæmor-

rhoids by the use of injections into the tumors. As to the question of danger of the operation, I have never witnessed any unpleasant results.

In the operation which I have now performed for several years, with a result highly creditable to myself, there is required no great amount of anatomical or surgical skill, and if you will faithfully follow the direction I am about to give you, you will need fear no evil consequences.

If called to see a patient when the tumors are down, as you will often be called upon at this time, you will find the patient generally in bed and in a most excellent humor to be operated upon, as the piles which have been prolapsed perhaps three to four hours will be swollen, congested, livid and more or less œdematous, and any attempt to replace them will cause exquisite suffering.

The prolapse of the tumors has generally been caused by defecation a short time previous, so there is often no necessity to move the bowels by injections. I then commence the operation by greasing the tumors and all the surrounding tissues with Cosmoline and then with a hypodermic syringe filled with a fluid in the following proportions : Carbolic acid and Glycerine, equal parts, added to four times the amount of distilled water, plunge the needle into the tumor, passing the needle into as near its centre as possible, and on gently and slowly withdrawing the instrument, force from three to ten drops into the tumor. This will give no pain whatever, unless some of the fluid gets upon the surrounding tissues.

I generally wait about three minutes, watching the hole made by the needle, to see that no oozing takes place, for if it does, the operation for that time will be a failure. Then gently but forcibly replace the mass above the sphincter, telling the patient to lie still for an hour, then if not contra indicated, to get up and go about his business as usual.

I never operate but upon one tumor at a time, and never more frequently than once a week.

If from any cause whatever the patient should experience any pain I always give an injection of about an ounce of Olive or Castor oil, and that will bring relief instantaneously.

This procedure is simple enough upon the first tumor, but when your patient returns the second time, he comes under similar conditions to what the majority of patients have with internal hæmorrhoids, that is, the tumors are not down, but above the sphincter.

If gentle straining will not bring them down, you will be required to use an anæsthetic and dilate the sphincter, but this is not necessary, only very seldom, as gentle straining will bring them completely into view, if only partially, gentle manipulation will accomplish all that is required.

The second operation is similar to the first, except if the first tumor is not entirely absorbed, I operate upon it again, using an amount of fluid according to size.

At each successive operation, always inject a new tumor, besides treating any of the older ones that require it.

The injection of this strength never produces a slough, but seems to cause an atrophy of its internal parts, and nature removes it by absorption.

I consider that the use of this fluid in strength sufficient to cause a slough is unnecessary and extremely dangerous.

Ergot and Subsulphate of Iron have been recommended as injections in internal piles. Of the latter I have no experience, and of the former, in two cases in which used, I found it very inefficient.

There are many other modes of operating recommended, but I have never seen cause to change from the above, as the result has always been favorable.

CHAPTER X.

ABSCESS OF THE RECTUM.

SIMPLE ABSCESES.

Abscess in the neighborhood of the rectum and anus is quite a common affection. There is hardly a physician, even of an ordinary practice, who will not meet one or more cases every year, and to our surgeons and specialists it is an every day occurrence to meet these cases of abscess of the rectum. Let me say right here, that the practitioner who is familiar with the different phases of this disease has it in his power to prevent great suffering and inconvenience and often save life. And to the Homœopathist it is of the greatest importance to early recognize this trouble, for with the knife to give vent to the discharge at an early day and his well selected remedy to follow, that most dreaded disease, fistula can most frequently be avoided.

An abscess here as in other parts of the body arises from alteration or actual death of a portion of tissue. This necrosis or change in quality of tissue, the ultimate cause of every abscess, when not due to the presence of a foreign body introduced into the body, may originate in traumatism. Abscess of the rectum may be caused by perforation from substances that have been swallowed, and have lodged in the rectum, ulcerating into the connective tissue surrounding, where they are often found after lancing. They may be pins, needles, fish bones, seeds, etc.; abrasions caused by impacted fæces, or substances introduced through the anus may cause a perforating ulcer which will be the origin of an abscess. Other causes, such as contusions from kicks or riding horseback, pressure of stricture or cancer of the rectum and finally the tubercular diathesis.

Before describing any of the various forms in which we encounter abscesses in the neighborhood of the anus in practice, it is important to observe that they all have characteristic features in common, viz.,

1. They can rarely be made to abort, going on almost always to supuration.
2. They do not heal readily but as a rule tend to degenerate into chronic sinuses and fistulæ.
3. The pus they discharge is offensive in odor in consequence of the exosmosis of gases.

Abscesses in the region of the rectum and anus vary much in size and gravity. I have been called to patients whose first expression was "Doctor I have piles, and they are so painful that they prevent my moving or doing any work, even sitting down is painful." Further inquiry will develop the fact that this is of very recent origin, sometimes only a few hours, seldom over forty-eight, and upon examination I found a little round enlargement formed just at the verge of the anus, hot and painful, the presence of which excites spasmodic contraction of the sphincter, by which it is pinched, adding much to the patient's sufferings.

These little abscesses are very much like those which appear on the eye lids, (hordeoli) and apparently originate in the glandular follicles and cause an amount of pain out of all proportion to their size, they often leave behind them a minute "blind" external fistula, which keeps up a discharge of a small quantity of pus or a watery offensive discharge which is very disagreeable to the patient.

MEDICAL AND SURGICAL TREATMENT.

Treatment.—If called at an early period in the formation of the abscess, you can often abort it by the application of Iodine or Turpentine applied with a camels hair brush, combined with the internal use Belladonna, Sulphur or Pulsatilla, etc. If called upon later when pus has formed, open it with a lancet, and save your patient great pain and suffering, for it may not open spontaneously for from two to five days, giving great pain in the mean time. And here let me add a few directions in regard to the use of the lancet in this disease, and what I say will apply to all cases where it is necessary to use a knife in the region of the anus. "All incisions should radiate from the anus as a centre." The reason for this rule is that you avoid cutting across the general course of the blood vessels, and escape possible effects of subsequent contraction in healing.

DERMOID ABSCESS.

There is another kind of abscess that forms near the anus, and is sometimes called the "*dermoid*" abscess, it is generally as painless as the first described was painful, it often discharges and leaves a little fistula without the existence of the abscess having been known. As it is generally so free from pain, it is not usually brought to the notice of the physician or surgeon until the constant slight discharge attracts the attention of the patient, who is often a delicate phthisical person. A local stimulant is generally all that is required to cure the case.

LOCATION OF THE ABSCESES.

The most common form of acute abscess in this region is where the focus of pus formation is situated farther from the verge of the anus and beyond the grip of the sphincter. The pain in the most acute grade is not so constant or severe as the first variety, although we have a greater redness of the skin and more febrile reaction. The complete relief that is experienced upon the evacuation of the abscess, whether artificial or spontaneous, leads the patient to dismiss the trouble from his mind, and it is only some weeks later that the fact is forced upon his attention by the soiled condition of his clothing.

Sometimes when the collection of pus is near the level of the upper limit of the sphincter muscle, it may fail to reach the surface externally, and discharge its contents into the bowel, forming what is sometimes called the blind internal fistula.

Generally we find, however, this condition is not permanent, for sooner or later we find the abscess again forming and it may break externally, and thus complete the fistula.

In these last two varieties the exciting cause is generally a perforating ulcer which forms at the bottom of one of the lacunæ of the rectum. The ulceration being generally provoked by the lodgement of some substance in these pockets, from the passing feces. Here you see we have an explanation of the fact that when a complete fistula follows one of these abscesses, its communication with the bowel is most frequently found just above the limit of the external sphincter muscle; sometimes the starting point of the abscess is in the substance of the sphincter, and the resulting fistula actually traverses the muscular mass. [See cut p. 67.]

ISCHIO-RECTAL ABSCESS.

When the abscess extends entirely out of the sphincter it occupies the space called the ischio-rectal fossa, where in the loose connective tissues the abscess finds room for development, and its progress is much slower and more insidious, and more dangerous, for the yielding power of the connective tissue tends to force the growth of the abscess more internal, than toward the strong, unyielding skin and fascia. In these cases we find the skin brawny and thickened over considerable extent, with a good deal of febrile excitement and frequent evidences of septicæmic depression.

If the surgeon is not familiar with these cases, and waits for evidence of fluctuation before interfering, extensive destruction of tissue may take place, and be a source of the greatest danger to the life of the patient, but if a finger is inserted into the rectum, it will readily recognize the increased heat and doughy feel. The surgeon should make an early and free opening through the integument. This affords the only assurance of safety.

There is plainly a wide difference between the little, round, painful abscess first described and the grave form last given; yet in practice we encounter many varieties of abscess, intermediate with these, and I would have you bear in mind that the same rule of treatment applies to all, viz, an early and free opening with the double object of shortening the period of pain and tissue destruction, and securing a cure if possible without a fistula.

PELVO-RECTAL ABSCESS.

Occasionally abscesses form in what is called the superior *pelvo-rectal space*. The symptoms accompanying the formation of an abscess in this region are very obscure, and its progress very slow, in consequence of the difficulty with which the pus finds an outlet, ultimately the pus discharges high up in the rectum, or by a circuitous route, gradually finds its way out from the pelvis through the sacro-sciatic notch, gravitating downward beside the rectum points externally near the anus, constituting a variety of fistula very difficult to diagnose as well as cure. This is one example of a variety belonging to our category of abscesses near the anus and rectum which we cannot open early, simply because we cannot reach them even if accurately diagnosed. I could not have covered this subject, nor could I have completed the etiology of fistula (as far as fistula takes origin in abscess) without mentioning them.

TREATMENT OF ABSCESES.

The *treatment* of abscess in the region of rectum and anus is the same as in any other portion of the body; in the first stage, by the appropriate remedy to abort the disease—which is often done by the well selected Homœopathic remedy. When pus is formed, give it as early and free an opening as possible, and by appropriate local treatment, such as Carbolic acid injections, etc., wash out the sac and get adhesions between the walls as soon as possible, which if you are unable to do, it will become a fistula, the treatment of which will follow in the next chapter.

CHAPTER IX.

FISTULA IN ANO.

COMPLETE, BLIND EXTERNAL AND INTERNAL FISTULÆ.

It is not often that one sees a rectal abscess very early, either the patient is not aware of the importance of attending to the early symptoms, or he temporizes, using fomentations or poultices, or when seen by a physician the proper treatment is not always promptly adopted. In the majority of instances, the physician's attention is not called to the case, until it has become a complete fistula, when examination may reveal it to be the most trivial matter which can be operated upon at the office and the patient sent about his business, or he may find it to be a most serious affair, demanding extensive surgical interference. I have seen a fistula so insignificant, that it was almost impossible to make the patient believe it was a fistula and needed treatment, and again I have seen others where the buttock was so riddled with sinuses as to resemble a rabbits warren more than anything else.

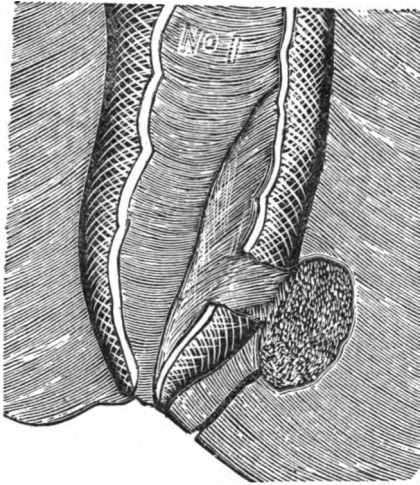
Fistula may exist for years without causing much pain or inconvenience to the patient. I know one person who has had an anal fistula for over twenty years, and it has caused him so little trouble that he never has had anything done except the occasional passing of a *probe* when one of the external apertures (there being three) gets blocked up and pain caused by the retention of matter.

VARIETIES OF FISTULA.

Anatomically considered there are three forms of fistulæ, viz., *complete*, *blind external* and *blind internal*, the first being the most commonly met with, and it is one where there is an external opening near the anus and an internal one with a more or less crooked sinus between the two.

A blind external fistula is one where there is an external, but no

internal opening. A blind internal fistula is so-called from there being an internal opening without any external one. I said anatomically considered there are three forms of fistula but practically we need consider but one, the complete, for the blind internal will soon make itself into the complete if let alone, and the most experienced surgeons advise you to make it a complete one at as early a period as possible. The blind external is most successfully treated by transforming it as soon as possible into one of the first variety.



ABSCESS AND FISTULA.

The best manner to make an examination in a supposed case of fistula, is to place your patient on a table on the side, upon which the fistula is supposed to be situated, with the buttocks close to the end and the knees flexed close against the abdomen. You will then see the orifice of the sinus or some discoloration of the skin indicating the site of the disease. The sinus may often be detected by passing the finger gently around the anus where it will be felt like a pipe stem beneath the skin. Then pass a probe into the external aperture, holding it very lightly in the hand, it will almost find its own way, when it has been passed as far as it will go without using any force, introduce the finger into the rectum, where you will ordinarily find the probe, or detect its position still beneath the covering of the bowel.

Now with the finger explore the rectum for the internal opening, an educated digit will nearly always detect it. Having found the opening, you can with the other hand guide the probe towards it.

It is said that occasionally you will find more than one internal opening, it is well to examine for extra ones, but it has never been my fortune to meet with one of these cases.

It is very important that this internal opening be felt with the finger for in operating it should be included in the incision.

SURGICAL TREATMENT OF FISTULÆ.

Being satisfied that a fistula exists, the next question is naturally what is the best mode of treatment, and here you will often be asked, can it be cured without the use of a knife. To this I am in the habit of replying that fistulæ have been known to get well with and even without treatment, but as a rule these are the exceptions and should not be depended upon. If the fistula be a blind external one, or of the simplest variety of complete, you stand an excellent good chance of curing your case by the following treatment: Enlarge the external opening by a tent or with the knife, this you will find very necessary and apply Carbolic acid in solution of Glycerine, (one part of acid to two of Glycerine,) and put in a drainage tube.

This mode of treatment if carried out with care and perseverance, offers, in my opinion, the best chance for the patient, yet with this you will frequently fail, and then it will be necessary to adopt either the knife or ligature.

The mode of cure by the elastic ligature has the strongest advocate in Dr. Allingham, who has invented a set of instruments for facilitating the passage of the ligature. Dr. Helmuth, of New York, has modified the instrument and I think with advantage, but the least elaborate and most effective and least costly instrument for the purpose is a simple eyed probe, which is threaded with the elastic cord and passed through the fistula and out at the anus, drawing the cord as tight as possible and then fasten it in that position by slipping over it a soft metal ring and squeezing its two sides together close up against the tissue. The ligature will be found to have cut its way through the included mass in the course of a few days, the time depending on the quantity and quality of the mass to be cut.

The great advantage claimed for this mode of treatment, is that the patient is allowed to go about his ordinary pursuit, there being no hæmorrhage and it is not particularly painful in its application.

My experience in the first few cases were very gratifying but after that I had two cases which complained most bitterly of pain for at least forty-eight hours, and I must plead guilty to the preference for cutting with the knife when cutting is necessary. I now use the knife in all cases except where there is danger of hæmorrhage or where the patient refuses positively to submit to a cutting operation.

Before proceeding to operate upon a case of fistula by incision, he observance of several minor details will greatly facilitate matters, viz., the thorough emptying of the bowel the day before, and a thorough cleansing with injection immediately before the operation, then with the patient placed on a table in the position described when making an examination and thoroughly under the influence of Ether, (and you will always find it to your advantage to use an anæsthetic,) introduce a probe director well oiled, and pass it into the external opening through the sinus and internal aperture if possible; then insert your finger into the rectum, and on feeling the point of the director draw it down and turn it out at the verge of the anus, this being done, with a curved probe pointed bistoury divide the tissues bridge over the director. This seems simple enough, but there are several things to be considered here.

1. You may not find any internal opening.
2. After division there may be considerable hæmorrhage.
3. The director must be forced out of the anus on the same plane as the sinus.

If there be no internal opening, you will probably find some point where only mucous membrane intervenes between the probe and your finger, gently work the director through and bring down the point as before. If you have severe hæmorrhage, control it by torsion, or any means at your command.

If the director is not brought out of the anus on the same plane as the sinus, you will find your tissues will be cut on a slant, and one side retracting more than the other prevents healing. This accident will give your patient considerable trouble afterwards by one side being raised above the other. This happened to one of my patients and it was over a year before the patient felt entirely comfortable.

Having now opened the fistula, search for lateral sinuses, and if any and not too many nor too extensive, they should be laid open, but it is impossible to give here anything but general directions. It has been my principle never to lay open more than two sinuses besides

the main one, at one operation, for fear of imposing too heavy a task upon the reparative powers of the patient.

After the completion of the operation, take some finely carded cotton and carry it clear to the bottom of the wound, packing it carefully in every part, being the more particular as the incisions have been extensive or high up in the bowel, then place a firm compress between the buttocks and over the wounds, and apply a T bandage firmly. I do not disturb this dressing until the third day when it will generally be found that the bowels have moved and the cotton has all come away, if not I remove it gently, and either replace it or let the patient alone, according to circumstances, and am not an advocate of repeated dressings unless the wound becomes unhealthy or sluggish. I always make it a point to watch my patient until the wound is completely healed, watching during the healing process for any burrowing or formation of fresh sinuses, the first symptom of which will generally be a sudden increase in the purulent discharge.

MEDICAL TREATMENT OF FISTULA.

Some physicians have claimed their ability to cure this disease by internal medication. I can only say that I can not, or at least have not been able so to do.

CHAPTER XI.

CONSTIPATION.

VARIETIES, CAUSES AND TREATMENT.

The great frequency of this affection in the different grades and classes of society, and the serious consequences which occasionally follow its presence, will, I trust, plead my excuse if I enter somewhat fully into the discussion of this subject.

Nature.—By constipation we understand a state or condition of the bowels in which the evacuations do not take place as frequently as usual, or are inordinately hard and expelled with difficulty.

VARIETIES OF CONSTIPATION.

Physiological Constipation.—I may here observe that to a certain extent constipation may be relative. One person may be constipated, though he may go to stool every day, while another person may be considered relaxed in his bowels, although he may have but one evacuation every three or four days. If the former habitually had two or three stools in one day, and the second ordinarily had but one in six days, the quantity evacuated might in each case be about the same, and both might come within the bounds of physiological constipation and enjoy perfect health.

If we seek the cause of these differences in the periodicity of the evacuations which are unaccompanied by any disturbance of health, we find that they depend almost exclusively upon purely individual variations from the average normal activity of the peristaltic action.

Pathological Constipation is a symptom of different pathological processes, and of very varying significance.

As a temporary condition, or as the accompaniment of various affections, it has scarcely any real clinical interest, yet in other cases

as in constriction or occlusion of the intestine, it belongs among the symptoms which are most important in the diagnosis and prognosis.

In a third set of cases, constipation has a certain independence; it causes a series of symptoms in different and distant organs, and is the starting point and the most prominent symptom of an affection which the practicing physician meets with constantly, and for which, considering the uniformity of the symptoms composing it and the differences in the individual cases in its very often uncertain etiology, the symptomatic title of "habitual constipation" is justly maintained.

CAUSES OF CONSTIPATION.

Causes.—If we exclude all those cases in which the constipation is due to mechanical obstruction, we will find the ultimate cause of most of the other kinds lies in a sluggishness or weakness of the peristaltic action of the intestines.

The causes of this condition are extraordinarily manifold. Frequently there are many forces at work at the same time, and it cannot often be determined which was the primary one or the most important.

An increased excretion of water through the skin and lungs, or the kidneys, causes constipation, unless compensated for by abundant drinking. On the other hand, free drinking of water, if the amount absorbed is less than that taken, often causes diarrhœa.

In this case the diarrhœa depends upon an increased peristaltic action; and in the former, the constipation is caused by a diminution of the same—and some of the most remarkable cures in cases of chronic constipation have been made by advising the patient to drink water more freely than usual.

Among the many causes of chronic constipation, chronic intestinal catarrh may be mentioned as the most frequent.

Whilst diarrhœa usually accompanies acute catarrh, in consequence of increased excitability of the intestinal mucous membrane, the chronic catarrh of adults is *always* associated with constipation. The principal cause of which is to be found in the muscular coat itself, which in all protracted cases participates in the abnormal nutritive changes carried on within the mucous membrane and becomes flaccid, in the same way as does the muscular coat of the bladder in chronic cystitis. As a result of this relaxation of the

muscular coat, together with the inelasticity of the intestinal walls, (which is produced by the same cause) the production of meteorism is favored.

Under healthy conditions every great accumulation of gas within the intestine is relieved by the increased peristaltic action, produced by the intra-intestinal pressure, but on the other hand the diminished elasticity of the walls prevents the accumulation of gas from increasing the intra-intestinal pressure, therefore peristaltic action is not excited and the condition becomes chronic.

These cases of habitual constipation are often associated with hypochondria, and from their history we learn that the trouble has usually lasted a long time and developed very gradually, the mental depression appearing later as a secondary symptom. The patients are generally men of sedentary habits between twenty and forty years of age.

The symptoms in these patients are most various. A sense of oppression and obstruction of respiration, palpitation of the heart, a feeling of pressure and fullness in the abdomen, symptoms which are due to the existing meteorism and the elevation of the diaphragm caused by it.

In addition they often complain of faintness, ringing in the ears, rush of blood to the head, headache, sensation of heat or cold in the extremities, pains in the back, dragging and dull pains in the genitals, etc.

The favorite theory is that these pains are caused by pressure of the overloaded intestines upon branches of the lumbar plexus, but the truth is we are far from being able to give a sufficient causative explanation of even a small part of these abnormal sensations.

Chronic constipation may have its origin primarily in the large intestine for it is plain that an abnormal weakening of the peristaltic action of the colon united perhaps with insufficiency of the abdominal pressure which is essential to the emptying of the rectum, causes constipation even when the peristaltic action of the small intestine is normal.

A detailed consideration of the causes of constipation arising in the colon would render many repetitions unavoidable for the causes already described affect the colon as well as the small intestine.

Nevertheless it will be necessary to mention some of them, because

many of the circumstances belonging to it have a certain independence in their causes, symptoms and course, the principal one of which is the abnormal length and arrangement of the colon.

This abnormal arrangement of the colon was often mentioned by the oldest writers as something important, described with great detail and not unfrequently illustrated by many sketches, but more modern researches have proven that this anomalous disposition of the colon is in most cases, so long as it does not become excessive, an entirely insignificant symptom. Normal peristaltic action overcoming all obstacles offered by the numerous curves as it does for those of the normal flexures. But if there is a notable diminution of the forces which advance the feces and empty the rectum, be added to the above described disposition of the colon, constipation follows, and is severe in proportion as the abdominal flexures are more numerous.

Constipation is frequently caused temporarily by change of diet, scene or habits, among which latter may be included, anything which interferes with the regular performance of defecation. It is an accompanying condition in most cases of chlorosis and dyspepsia.

It occurs too often, perhaps as a result of habit, in persons young and old, in which no special cause for it can be recognized, and indeed, in many of the most remarkable cases that come under observation it is quite impossible to assign a definite cause for it.

HYGIENIC TREATMENT OF CONSTIPATION.

The *treatment* of constipation to be successful must be made to depend more or less upon its cause, on its antecedents, and on its effects. Where it is a mere temporary matter, depending on accidental circumstances, or arising in the course of acute diseases, its treatment is simple enough, but when it has become a chronic affection, its causes should be investigated and as far as possible obviated for its sympathetic effects extend to every organ in the body and often occasion great distress and anxiety to the sufferer leading them to apprehend the existence of the most serious organic disease.

It is too frequently the case, that the most inappropriate means are adopted to remedy this condition. Many people are in the habit of dosing themselves with Calomel, blue pills, or some saline purgatives which, besides teasing and tormenting the upper part of the alimentary canal for no fault of its own, is productive of only temporary

relief and often much permanent harm. I could cite many instances which have come under my own observation of the mischief that has thus been induced, and indeed all authors on this subject make the same remarks.

In overcoming habitual constipation, much may be accomplished by proper hygienic measures, and indeed in many cases you will signally fail if you do not insist upon dietetic and hygienic measures.

In attaining this object, it is essential that the patient should "solicit nature" at a certain period of the day, immediately after breakfast being the best time.

Exercise is most important to the proper performance of defecation, and it is highly essential that all who are able should take daily exercise; if, from bodily debility or other causes, the patient is unable to leave the house, frictions of the abdomen at the closet or while in bed, should be resorted to.

A glass of cold water taken early in the morning, will materially assist in promoting the peristaltic action of the intestines.

Enemata of cold water after an operation is an important adjunct.

Brown bread is very useful in promoting the action of the bowels, yet in some cases it will produce pain in the epigastrium, flatulence and heartburn. No plan of diet can be set down that will suit all cases, but each case must be individualized and a diet prescribed that will suit it. The secret of success here is, getting a diet that is easily digested and assimilated, and that of nourishing material.

MEDICAL TREATMENT OF CONSTIPATION.

Remedies.—For morbid states wherein constipation is the prominent symptom, the following have been found the most effectual remedies in my hands: Bryonia, Lycopodium, Nux vomica, Natrum muraticum, Alumina, Belladonna, Opium, Plumbum, Phosphorus, Sulphur, Hydrastis, and *Æsculus hippocastanum*.

Sulphur.—Dr. Richard Hughes says the treatment of chronic constipation may be advantageously commenced with Sulphur. A statement that I have found of the greatest practical importance. He advises that it be discontinued or changed to some other remedy at the end of a week. That I have always followed except when the following symptoms are present, when I find it far preferable to continue it longer. Where we have hard, knotty stools, alternating

with diarrhoea, particularly if the subject is hypochondriacal or hæmorrhoidal, with the well known symptom of goneness in the stomach at 11 A. M.

Sulphur and *Nux vomica* in alternation have proved valuable in many cases where we have periodical attacks of constipation alternating with a fair condition of the bowels preceding the attacks of constipation. We have the general malaise, slight nausea, eructations, bloated abdomen and coated tongue, with headache, a condition so often spoken of as bilious.

Nux vomica is of great value in constipation connected with sedentary habits when there is a general condition of dyspepsia. Often with ineffectual urging before stool, the stools being large, hard and dry, with oppression of spirits, no desire for work, passive frontal headache, which is worse in the mornings; bloating of the abdomen which produces dyspnoea from pressure on the diaphragm. The following case will illustrate the sphere and action of *Nux vom.* :

CASE XXII. Mrs. S., thirty-three years of age, says she has been costive all her life. Had previously taken a great deal of medicine, with only temporary relief. Says her stools are large and painful to pass, only moving about once in five or six days. Feels much better after an operation, but in a day or so begins to suffer with bloating and pressure in the bowels, aggravated after meals, inclined to wake up in the night about the same hour. Very sleepy in the morning. Was confined about a year ago. Her condition has been worse since. Says she has headache all the time, and her tongue is never free from a coat, with a bitter taste in the mouth every morning. Does not drink coffee; it always made her worse. Thinks she is now beginning to suffer from *piles*. *Nux 2x* three times a day cured in a month, and she has remained so now for three years.

Bryonia is most useful in constipation occurring in the summer, and in the rheumatic diathesis, when the stools are hard and dry, as if burned. Acute attacks of constipation occurring in women during the lying-in period (possibly depending upon some inflammatory irritation of the abdominal organs.) It is the best remedy in my hands for constipation in infants who are being raised on cow's milk, or in cases of acute constipation in children following an attack of gastro-enteritis.

Alumina.—I have never had occasion to use *Alumina* but in one case, and then its effects were so remarkable that I feel that it must be recorded here.

CASE XXIII. Mrs. G. S., aged thirty-three, constipated for ten years, never having an operation without the use of some medicine or injections, had gone as high as thirteen days without moving. There seemed to be a dryness of the rectum. The fæcal matter would accumulate in the rectum until it seemed distended to its fullest capacity. It might well be called a case of *inertia*. *Alumina 6x* cured entirely in six weeks, and after a great many other remedies had been tried and failed.

Opium's sphere of action is limited to those cases where there is great torpidity, which we are apt to find in persons of sedentary habits, who do much head work; with sensation of fulness and heaviness in the abdomen, dryness of the mouth, with attacks of congestion to head, red face and headache.

Plumbum is allied closely to *Opium* in its action in constipation, and is chosen in preference to *Opium* in those cases where we have the same torpidity, etc., but the stools, instead of being large, are composed of small, hard balls, sometimes enveloped in a light, greasy pellicle.

Hydrastis.—Dr. Hughes says he does not know of a remedy which is of greater service in simple constipation than *Hydrastis*. This statement I have verified many times, but its sphere of action is limited to one particular kind of cases, and I have never obtained any benefit from its use in any other, viz., those cases of so-called biliousness, where symptoms of malaria, headache, gastralgia, etc., are always preceded for about two days or more with constipation. And we generally find the patients have regularly indulged in purgatives of some kind, with relief, and they lay great stress on the constipation, saying if they could keep their bowels regular they would have no trouble. It is in those cases alone that I have found *Hydrastis* useful.

Phosphorus.—I had always been taught and supposed that *Phosphorus* was especially indicated in tall, slender persons with a weakness of the procreative system, and in my efforts to cure constipated persons of that temperament the result was too often failures to be satisfactory, until at last I almost discarded *Phosphorus* from my list of remedies for constipation. But my eyes were opened to its proper use in prescribing for a cough in a large fleshy female with a violent short hacking cough, with aphonia. Under *Phosphorus* her cough rapidly disappeared and with it her constipation which had

been troubling her for years. Since then I have used Phosphorus in the lymphatic temperaments, where we have the long slender hard stool, and it has proved eminently successful.

Æsculus hippocastanum.—My record book shows but few cases of constipation cured with *Æsculus* and none unless accompanied by hæmorrhoids. In cases of piles when constipation is a prominent symptom, this remedy is highly recommended by all authors and I can only add my testimony to theirs.

Lycopodium.—Dr. J. P. Mills, of Chicago, in a paper read before the American Institute of Homœopathy considers *Lycopodium* as the remedy for infantile constipation and colic. Since reading that article I have followed his recommendations and have found it almost a panacea in cases of constipation in children. In this it very much resembles *Bryonia*, but the point of distinction between *Lycopodium* and *Bryonia* is, the former is accompanied by great flatulency. *Lycopodium* has also proved useful in constipation of old people and in those whose vitality is very low when there is no desire for stool, the stools are semi-solid, or first part solid and last part thin and watery.

CASE XXIV. G. H. N. aged eighty-one, had been very costive for years, now very feeble, he suffers very often with flatulent colic brought on apparently by indigestion, generally obtained relief from *Asafoetida*. *Lycopodium* 12x relieved in two days, and after continuing had no further trouble.

Natrum muriaticum.—My list of remedies closes with *Natrum muriaticum*, which is indicated if there is fissure at the anus with throbbing, tearing and burning pains in the rectum. When the constipation is increased and aggravated from unwillingness to go to stool on account of pain produced by defecation. It supplies the place usually given to Phosphorus in tall slender persons, when there is a dry state of the system and the sallow complexion characteristic of the drug.

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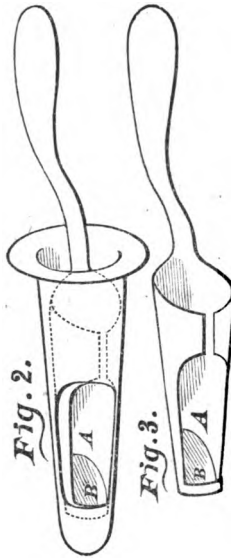


Fig. 2 is an outline drawing showing the parts of the Speculum in position. Notice that the interior portion A, has one side cut away, which may be adjusted to coincide with opening in outer shell.

Fig. 3 shows the interior part marked A, removed from the outer shell. The inclined portion B, is for the purpose of facilitating with drawal, as it offers less resistance than an abrupt shoulder. It will be seen that the Speculum admits of being perfectly cleaned in every part.

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The skill of Dr. Campbell as a specialist of the diseases of the eye and ear is well-known and this work will prove a blessing to those who are deprived of the inestimable boon of perfect hearing. The numerous mechanical appliances for the assistance of the deaf are named and described with rare clearness and knowledge. Of course the inventor of each claims superiority over all others, and those who seek relief are confounded by the rival arguments presented. Dr. Campbell, with scientific discrimination, has given the facts as he found them, and from his evidence the afflicted may intelligently determine for themselves. The number of helps to hearing described will be a surprise to those whose attention has been called to the subject. As this work covers an unworked field in scientific literature, success will surely follow.—*The Spectator*.

"*Helps to Hear*" is the title of a little volume written by Dr. James A. Campbell, a professor in the Homœopathic Medical College of Missouri, and just published by Duncan Brothers, of this city, who are also publishers of a great many other medical and semi-medical works. It opens with a brief exposition of the anatomy of the ear, of the nature of sound and of the method of its transmission, and then proceeds to a description of all the various artificial aids to hearing from the simplest form of the ear trumpet down to the audiphone, and even the telephone of our day. These descriptions include a statement of the principles of construction of all these, and of the theories of their operation, and the little volume closes with some rather enthusiastic speculations as to the possibilities of the use of the principles involved in the operation of the telephone in devising further aids to the deaf. The number of those whose hearing is more or less weakened either congenitally, from disease, or other causes, is very much larger than one would at first suspect, and these comparatively few have any knowledge of the various mechanical appliances for assisting the ear. Even among medical practitioners this knowledge is comparatively rare. Scarcely anything has been written on the subject and this little book, which seems to be very fair and very full, containing descriptions, with illustrative cuts, of all known devices in the direction named, ought to be very welcome to both professional and non-professional readers.—*Chicago Times*.

